

2018 PA Super 16

ANITA E. TONG-SUMMERFORD, AS	:	IN THE SUPERIOR COURT OF
ADMINISTRATOR OF THE ESTATE	:	PENNSYLVANIA
OF MARVIN JEROME SUMMERFORD,	:	
DEC.	:	

v.

ABINGTON MEMORIAL HOSPITAL
AND RADIOLOGY GROUP OF
ABINGTON, P.C. AND KRISTIN L.
CRISCI, M.D.

No. 3114 EDA 2016

APPEAL OF: ABINGTON MEMORIAL
HOSPITAL

Appeal from the Judgment Entered September 2, 2016
In the Court of Common Pleas of Montgomery County Civil Division at
No(s): No. 2010-35494

ANITA E. TONG-SUMMERFORD,	:	IN THE SUPERIOR COURT OF
ADMINISTRATOR OF THE ESTATE	:	PENNSYLVANIA
OF MARVIN JEROME SUMMERFORD	:	

v.

ABINGTON MEMORIAL HOSPITAL,
RADIOLOGY GROUP OF ABINGTON,
P.C., VALERIE BONICA, D.O. AND
KRISTIN L. CRISCI, M.D.

No. 3310 EDA 2016

APPEAL OF: RADIOLOGY GROUP OF
ABINGTON, P.C., AND KRISTIN L.
CRISCI, M.D.

Appeal from the Judgment Entered September 2, 2016
In the Court of Common Pleas of Montgomery County Civil Division at
No(s): No. 2010-35494

BEFORE: PANELLA, J., OLSON, J., and STEVENS*, P.J.E.

OPINION BY STEVENS, P.J.E.:

FILED January 30, 2018

In these consolidated appeals, Appellants Abington Memorial Hospital (hereinafter "AMH"); Kristin L. Crisci, M.D. (hereinafter "Dr. Crisci"); and Radiology Group of Abington, P.C. (hereinafter "RGA") (hereinafter collectively, at times, "Appellants") appeal from the judgment entered in the Court of Common Pleas of Montgomery County on September 2, 2016, at which time the trial court denied their respective post-trial motions, molded the verdict of \$5,000,000 in favor of Anita E. Tong-Summerford, as administrator of the estate of Marvin Jerome Summerford, deceased, (hereinafter "Appellee") to add delay damages in the amount of \$947,157.53, and ordered the delay damages to be apportioned between the Wrongful Death Act and Survival Act claims in the same proportionate allocation as in the verdict: 30% (\$284,147.26) to the Wrongful Death Act claim and 70% (\$663,010.27) to the Survival Act claim. Upon our review, we affirm.

The trial court set forth the facts and procedural history herein as follows:

On November 30, 2008, Marvin Summerford, age 88, was transferred to the emergency department of Abington Memorial Hospital (hereinafter, "AMH" or the "Hospital") from a long-term care facility. Mr. Summerford's past medical history included dementia, hypertension, congestive heart failure, and pulmonary insufficiency. On December 1, 2008, Mr. Summerford suffered cardiac arrest secondary to pneumonia, and a code was called due to pulseless electrical activity, decreased heart rate, and low blood pressure. Mr. Summerford survived and was transferred to the ICU.

On December 2, 2008, a feeding tube was inserted and an order was placed for an x-ray to confirm proper placement.¹ The

x-ray revealed that the tube had been inadvertently inserted into the lung and was therefore removed. The feeding tube was re-inserted, and another x-ray was ordered to confirm proper placement. Again, the feeding tube was not properly placed.

On the next day, December 3, 2008, Valerie Bonica, D.O., an AMH resident, inserted a new feeding tube into Mr. Summerford. Dr. Bonica ordered a portable chest x-ray to confirm proper placement of the tube at 3:55 p.m. In response to this order, x-ray technologist Jillian Nickel, an AMH employee, performed a portable x-ray at 4:53 p.m. capturing the lower chest and abdomen.² This image was interpreted by Kristin Crisci, M.D., a radiologist, who incorrectly read the study as showing termination of the feeding tube in decedent's stomach when, in fact, it terminated in Mr. Summerford's left lung. Dr. Crisci signed her report at 5:33 p.m. She did not order additional imaging. In reliance upon Dr. Crisci's report, Dr. Bonica ordered administration of a feeding solution (Jevity) at 10 cc's per hour for the first eight hours. The first feed was administered at approximately 11:00 p.m. on December 3, 2008. From 11:00 p.m. to 7:00 a.m. the next morning, 50 cc's of Jevity and 420 cc's of flush was administered through the feeding tube into Mr. Summerford's lung.

Mr. Summerford's condition deteriorated. At 4:38 a.m. on December 4, 2008, Dr. Bonica placed a STAT order for portable chest x-ray to aid in the diagnosis/treatment of pneumonia. The x-ray was completed at 4:46 a.m. but was not analyzed by a radiologist until 8:13 a.m., at which time the radiologist recognized the feeding tube was positioned in Mr. Summerford's left lung. By this time, Mr. Summerford had already been pronounced dead at 7:11 a.m. on December 4, 2008.

After a five-day jury trial, the jury returned a verdict on May 13, 2016 in favor of [Appellee] and against [Appellants] AMH and Dr. Crisci/Radiology Group of Abington, P.C. (hereinafter, "Dr. Crisci")³ in the total sum of \$5,000,000 (\$1.5 million for the wrongful death claim and \$3.5 million for the survival action claim). The jury apportioned liability as follows: AMH 25% and Dr. Crisci 75%. The verdict was molded to add Rule 238 delay damages for [Appellee] and against [Appellants], resulting in a molded verdict in the amount of \$5,947,157.53.⁴

AMH and Dr. Crisci each filed timely motions for post-trial relief seeking judgment *n.o.v.*, a new trial, and remittitur. Following oral argument, on September 2, 2016 this court denied [Appellants'] post-trial motions, molded the verdict, and entered judgment on the jury verdict in favor of [Appellee] and against

[Appellants]. Thereafter, AMH and Dr. Crisci filed timely appeals,⁵ which were consolidated on November 7, 2016 by Order of the Superior Court. On October 4, 2016, the court ordered defendants to file a concise statement of errors pursuant to *Pa. R.A.P. 1925(b)*.

¹ The feeding tube is supposed to be inserted into the esophagus and end up in the stomach. However, due to the close proximity of the esophagus and trachea in the back of the throat and the difficulty visualizing the proper placement of the feeding tube for insertion, occasionally the feeding tube is inadvertently placed in the trachea instead of the esophagus. Accordingly, it is necessary that an x-ray be obtained to confirm proper placement of the tube into the stomach, as opposed to the lung, before feeding solution is administered through the tube. All parties agreed that it was not negligence for a feeding tube to be inadvertently inserted into the trachea instead of the esophagus. N.T. 05.09.16 (a.m.), p. 19.

² There was disagreement whether the image captured by the portable x-ray was an abdominal study or a lower chest study. Dr. Crisci testified that notwithstanding Dr. Bonica's order for a chest x-ray, the technologist performed an abdominal study. N.T. 05.10.16 (p.m.), p. 93. [Appellee's] expert Dr. Igidbashian testified that it was an abdominal study. N.T. 05.10.16 (a.m.), p. 95. However, AMH's expert, Dr. Hani Abujudeh, testified that, " ... this was not a chest x-ray. It was not an abdominal x-ray. It was a hybrid x-ray, between a chest and an abdomen." N.T. 05.11.16 (p.m.), p. 144.

³ It was stipulated that Dr. Crisci was an employee/agent of Radiology Group of Abington, P.C. ("RGA"). By agreement of all parties, Dr. Crisci and RGA appeared together on the verdict sheet. N.T. 05.12.16 (p.m.), p. 89-91.

⁴ [Appellants] do not raise any issue on appeal regarding the addition of delay damages.

⁵AMH appeal Docket Number 3114 EDA 2016; Dr. Crisci appeal Docket Number 3310 EDA 2016.

Trial Court Opinion, filed 12/29/16, at 1-3.

On October 18, 2016, Dr. Crisci and RGA filed a timely Concise Statement of Errors Complained of on Appeal wherein they raised ten (10) issues. On October 25, 2016, AMH filed its Statement of Matters Complained of on Appeal wherein it also set fourth ten (10) issues.

In their brief, Dr. Crisci and RGA raise the following Statement of Questions Presented:

- A. Should the trial court have entered a judgment notwithstanding the verdict in favor of [Dr.] Crisci because [Appellee] failed to prove, by competent and sufficient evidence, her prima facie case of negligence against her?
- B. Whether the trial court erred in denying Appellants' Motion for a Non-Suit?
- C. Whether the trial court erred in denying a new trial on the basis of highly inflammatory and unfairly prejudicial statements made by Co-[Appellants'] radiology expert, Hani Abujudeh, M.D.?
- D. Whether the trial court abused its discretion and/or made an error of law in permitting [co-Appellants'] radiology expert, Hani Abujudeh, M.D., to testify to issues relating to the standard of care of Dr. Crisci, beyond the opinions testified to by [Appellee's] expert, which resulted in prejudice to Dr. Crisci?
- E. Whether the trial court committed an abuse of discretion and/or an error of law in only granting in part the Motion in Limine filed by Crisci to preclude [Appellee's] expert, Vartan Igidbashian, D.O., from testifying to causation issues outside his expertise?
- F. Whether the trial court committed an abuse of discretion and/or an error of law in denying a new trial because of improper statements made by [Appellee's] counsel?

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