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CASE NO. 17-CI-2399

JEFFERSON CIRCUIT COURT
DIVISION TEN (10)
HON. ANGELA MCCORMICK BISIG

KENDRA J. SMITH, Individually, as Administratrix of the Estate of JUSTIN M. SMITH, deceased, an as Next Friend and Natural Parent of N.S., L.S., and O.S. PLAINTIFFS

v. **DEFENDANTS' TRIAL MEMORANDUM**

UNIVERSITY OF LOUISVILLE PHYSICIANS, INC.; And FOREST W. ARNOLD, DO DEFENDANTS

* * * * *

Defendants University of Louisville Physicians, Inc. ("ULP") and Dr. Forest Arnold, by counsel, pursuant to the Court's Civil Jury Trial Order (Para. 14), submit their Trial Memorandum for the Court's consideration.

STATEMENT OF FACTS

This is a medical malpractice action. Plaintiffs allege that the decedent, Justin Smith, took a medication, Bactrim, three times in his life. Each time he took Bactrim, he became ill and was diagnosed with meningitis. The third time he was diagnosed with meningitis, he died from complications related to it.

Plaintiffs allege that Justin Smith's three meningitis episodes--including the one that led to his death--were Bactrim-induced ("BIM"). BIM is a rare form of meningitis. There is no test for it. Bactrim is one of the most prescribed medications in the world. There have been less than 50 reported cases in the medical literature of BIM. There has never been a reported

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fatality in the literature, even amongst patients who received Bactrim more times than Justin Smith. None of the experts in this case have ever diagnosed a patient with BIM.

The first time Justin Smith took Bactrim and developed meningitis, he was 16 years old. He was treated at Kosair Children's Hospital. The infectious diseases team did not diagnose BIM, or tell Justin or his parents to avoid Bactrim in the future.

The second time Justin Smith took Bactrim and developed meningitis, he was 28 years old. He was treated at the University of Louisville Hospital. The physicians at ULH were told that he had meningitis earlier in his life, but they were not told that his first meningitis followed a dose of Bactrim. They suspected that he had bacterial meningitis, which can be fatal if not treated promptly. The emergency medicine and hospitalist team initiated treatment. The hospitalist team then consulted Defendant, Dr. Forest Arnold, an infectious diseases specialist. He is a dual employee of ULP and the University of Louisville School of Medicine. Dr. Arnold made adjustments to the antibiotic regimen that was already in place, and Justin improved rapidly. Dr. Arnold diagnosed Justin with culture-negative meningitis. Just like the KCH infectious diseases team, he did not diagnose Justin with BIM or warn Justin never to take Bactrim again.

The third time Justin Smith took Bactrim and developed meningitis, he did not recover quickly. The meningitis apparently caused his brain to herniate, resulting in brain death. His family withdrew life support and he passed. This lawsuit followed.

Justin Smith's wife, Kendra Smith, has filed suit on behalf of his Estate. She has an individual spousal consortium claim. She has also sued as next friend to assert consortium claims on behalf of her three minor children. The only physician defendant named in the case

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is Dr. Arnold. Plaintiffs contend that he should have diagnosed BIM and warned Justin never to take Bactrim at the time of Justin's *second* meningitis. (They did not sue the infectious disease specialists who treated the first meningitis.) Plaintiffs have also have a claim against ULP for vicarious liability. There is not dispute that Dr. Arnold was acting in the course and scope of his employment when he provided care to Justin Smith.

Below is a more detailed discussion of the facts and issues. For the convenience of the Court, attached as Exhibit A to this Memorandum are two sheets identifying the parties, the expected witnesses and their relationship to the key events.

I. Meningitis One

The first time Justin Smith took Bactrim and was diagnosed with meningitis was in 2005. Smith was sixteen years old. His mother took him to an immediate care center, where he was diagnosed with a urinary tract infection and prescribed Bactrim. Bactrim is a common antibiotic that treats infections. It was first approved in 1973. It accounts for over 6 million prescriptions annually.

After taking Bactrim in 2005, Justin presented to the emergency room at Hardin Memorial Hospital with confusion, nausea and vomiting. He was diagnosed with meningitis and transferred to Kosair Children's Hospital ("KCH") for treatment. He developed seizures, agitation and confusion, bilateral nystagmus (involuntary eye movements), and had to be intubated and was on a ventilator for eight days. His mother, Michelle Smith, testified at her deposition that she thought Justin was going to die. Justin was discharged from Kosair after

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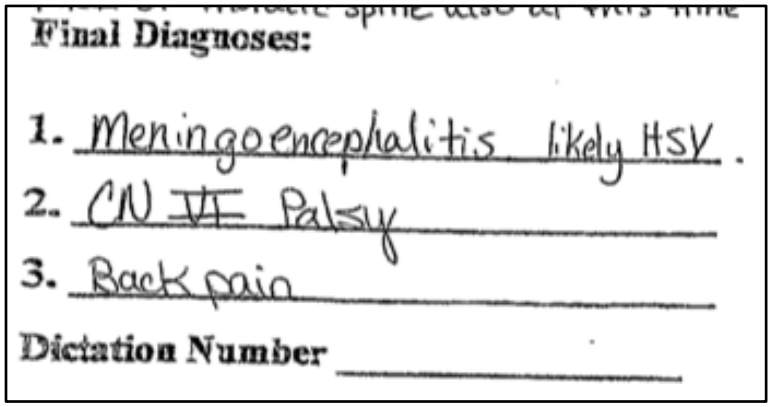
seventeen days, although he required an additional two weeks of inpatient care at Frazier Rehab.

Although one of the KCH infectious disease attending physicians, Dr. Christopher Harrison, initially considered BIM as one of numerous possible causes of Justin Smith's meningitis, the team ultimately concluded that Justin's meningitis was likely the result of herpes simplex virus ("HSV").[1] The word "Bactrim" appears nowhere in the hospitalist team's discharge note, which instead lists the following "Final Diagnoses":


Final Diagnoses:

1. Meningoencephalitis likely HSV.
2. CN VII Palsy
3. Back pain

Dictation Number

A copy of this note is attached as Exhibit B.

In response to Defendants' Requests for Admissions, Plaintiffs have admitted:

> *No one at Kosair Children's Hospital in 2005 informed Justin Smith or his parents that he should not take Bactrim in the future.*

See Plaintiffs' Responses to Requests for Admissions, attached as Exhibit C. However, Dr. Kristina Bryant, a pediatric infectious disease physician who treated Justin at KCH

[1] Indeed, another of the KCH attending physicians, board-certified pediatric infectious disease physician Dr. Kristina Bryant, did not know about Bactrim-induced aseptic meningitis when she saw Justin in 2005; she testified that, "Dr. Harrison educated me about Bactrim aseptic meningitis and why he thought it was a possibility in this case." (Dr. Bryant Depo. p. 33-35) (attached as Exhibit D).

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in 2005, testified that she discussed with Justin's family the possibility that his 2005 meningitis could have been related to his ingestion of Bactrim.[2]

II. Meningitis Two

Eleven years later, on April 20, 2016, Justin was in a serious motor vehicle accident. He was seen at Hardin Memorial Hospital, and then transferred to University of Louisville Hospital ("ULH") for treatment. He underwent five surgeries to address injuries in his left hand, his right ankle, and his left ankle, where he had sustained a degloving injury in the accident. He was diagnosed with two different sub-species of Serratia (a bacteria) following these surgeries and placed on an antibiotic. There was legitimate concern that Justin might lose his leg. After twenty-three days in the hospital, Justin was well enough to be discharged, but he remained in a wheelchair. He was directed to continue treatment with his orthopedic surgeon, Dr. Jiyao Zou.

Justin followed up with Dr. Zou in the clinic office. On June 16, 2016, Dr. Zou discussed a plan for Justin to undergo a procedure in which a rib would be transplanted to the medial malleolus (the inner side of the left ankle) at the end of the month, to attempt to reconstruct Justin's ankle. On that visit (and at prior visits), Justin reported an allergy to Penicillin, but not Bactrim. Plaintiffs have admitted:

> *As of June 16, 2016 (the date of Justin Smith's visit to the orthopedic surgery clinic), neither Justin Smith, Kendra Smith nor Justin Smith's parents had ever listed Bactrim as a medication allergy for Justin.*

See Exhibit C.

[2] Dr. Bryant Depo, pp. 53-54.

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At the June 16, 2016 visit, Justin's orthopedic physicians removed pins from his left foot but left an external fixator frame on his left ankle. Because of Justin's Serratia infection, Dr. Zou (assisted by his resident, Dr. Andrew Garber) prescribed Bactrim as a prophylactic antibiotic while he had the external frame on his left ankle. Plaintiffs have admitted:

> *When the Orthopedic Surgery team (Drs. Zou and Garber) prescribed Bactrim on June 16, 2016, neither Justin Smith, Kendra Smith nor anyone else on behalf of Justin Smith (including his parents) advised the team that Justin had an allergy to Bactrim, was suspected to have an allergy to Bactrim, or had been hospitalized in 2005 after taking Bactrim.*

See Exhibit C.

After taking one dose of the medication that evening, Justin presented to University of Louisville Hospital ("ULH") the following day, June 17, 2016, with a history of fever, vomiting, and increased pain around his injured ankle. While in the emergency room, he began to have seizures. Due to a concern for meningitis, Justin was started on empiric antibiotics (as bacterial meningitis can be fatal if not treated promptly). After the administration of antibiotics, a lumbar puncture was performed to collect cerebrospinal fluid ("CSF"). Blood was collected for a culture, and a CT scan of the head was ordered. Justin was admitted to the care of the ULH hospitalist team. The hospitalist attending physician assessed Justin with meningitis, most likely bacterial, and noted a history (per Justin's mother) of hospitalization at Kosair Children's Hospital for a meningo-encephalitis, possibly viral in nature. The hospitalist team asked Dr. Forest Arnold, the on-call infectious disease specialist, to consult on the case. In particular, the hospitalists sought his expertise to help manage the patient's antibiotics.

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Dr. Forest Arnold

When he was asked to consult on Justin Smith's case, Dr. Arnold had been in practice for nineteen years. He was double board-certified in infectious diseases and internal medicine. After completing his Fellowship in infectious diseases at the University of Louisville, he was invited to join the faculty, where he remains to this day. He is the Hospital Epidemiologist at UofL Hospital. He is the co-director of the Infectious Disease Fellowship Program. He has authored more than one hundred peer-reviewed research articles. He holds hospital privileges at UofL, Jewish, Norton, St. Mary's and Elizabeth, Floyd Memorial, Baptist Hospital, and the VA. This is the only lawsuit ever filed against him.

Dr. Arnold first met Justin Smith on day two of Justin's ULH hospital admission. Justin was somnolent (sleepy and difficult to arouse) after having received sedatives to address his seizures. Before Dr. Arnold's saw Justin, a consulting neurologist had him on Acyclovir to address possible HSV. Dr. Arnold was given the presumed diagnosis of meningitis. He considered that it may be either bacterial in origin or viral in origin (given that it was summer, when meningitides are more common, and Justin had three small children). Dr. Arnold continued antibiotics for bacterial meningitis (changing one antibiotic to address Justin's prior Serratia infection) and continued Acyclovir. He also added an enterovirus PCR panel to the CSF testing from the lumbar puncture. At this visit, Justin's mother informed Dr. Arnold that Justin had a remote history of meningitis from an unknown cause; but is undisputed that neither Justin nor his family told Dr. Arnold that he had developed meningitis in 2005 after having taken Bactrim. Indeed, Plaintiffs admitted that during Justin's

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admission from June 17 to June 25, 2016, Justin Smith, Kendra Smith, and Justin Smith's parents never:

> *Informed Dr. Arnold that Justin Smith had been hospitalized in 2005 after taking Bactrim;*
>
> *Informed any doctor or nurse at University Medical Center (including, but not limited to Dr. Arnold) that Justin Smith had been hospitalized in 2005 after taking Bactrim*; or
>
> *Informed Dr. Arnold that any health care provider in 2005 suspected there may have been a link between Justin Smith's 2005 admission and Bactrim.*

See Exhibit C.

By Dr. Arnold's second visit (on the third day of admission), Justin was responding well to treatment and was acutely improving. At the time of the third visit, the HSV PCR was negative and Dr. Arnold discontinued Acyclovir. While the CSF culture from the lumbar puncture was negative, the CSF was collected after Justin received several hours of antibiotics, which could have eliminated bacterial from the CSF (resulting in a condition known as "culture-negative" meningitis, which can be consistent with bacterial meningitis).

On Dr. Arnold's fourth visit, Justin was doing well and was stable. Justin wanted to go home. Dr. Arnold kept him in the hospital to complete a seven-day course of antibiotics to address culture-negative meningitis. Justin's enterovirus PCR result subsequently returned a negative result. Justin remained stable for the remainder of his admission, and the hospitalist team discharged him home from ULH after the antibiotic course was complete on June 25.

The course and outcome of this admission was markedly different from Justin's 2005 meningitis. Dr. Arnold was happy to see his patient make a quick, full recovery from what

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appeared to be a relatively common case of culture-negative meningitis. The fact that Justin improved is not in dispute. Plaintiffs have admitted:

> *Justin Smith's condition improved while he was under Dr. Arnold's care during the June 17, 2016 to June 25, 2016 admission.*

See Exhibit C.

Plaintiffs admit and it is undisputed that:

> *Dr. Arnold never prescribed Bactrim for Justin Smith.*

See Exhibit C. The evidence gathered in this case also shows that Dr. Arnold never told Justin Smith, Kendra Smith, or Justin's parents that he should resume taking Bactrim following his discharge from the hospital on June 25, 2016, although Plaintiffs refuse to admit this fact.[3]

III. Meningitis Three

Unbeknownst to Dr. Arnold, when Justin Smith returned home on June 25, 2016, he elected to take another dose of Bactrim that evening. He became restless. This time, the family suspected that Justin had an adverse reaction to the Bactrim. (This was the second time within a matter of days that he took the medication and immediately had symptoms.) He was taken back to the emergency room at ULH on June 26, 2016 at 7:21 am. He was agitated, tachycardic, alert, but not oriented. He was again diagnosed with meningitis, started on IV fluids and antibiotics, intubated, and admitted to the ICU at approximately 8:20 pm. At 4:35 am on June 27, 2016 (hospital day 2), an ICU nurse discovered an acute change: Justin's pupils were dilated and fixed. By 6:51 am, a physician confirmed this finding and a

[3] This is one of several Requests for Admissions that are at issue in Defendants' pending Motion to Determine the Sufficiency of Plaintiffs' Answers and Objections to Requests for Admissions.

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neurosurgery provider confirmed loss of brainstem reflexes on physical examination. Justin's wife and father were both present in the hospital and informed of his change in status. They requested an EEG, which confirmed that morning that he had no brain activity. That evening, KODA took over the care. Justin's body remained at ULH for organ recovery, which was completed on June 29, 2016. This lawsuit followed.

LIABILITY

Plaintiffs have disclosed Dr. Keith Armitage to provide expert testimony on their behalf. Dr. Armitage authored a five-page report in support of his opinions. He cited no research or literature in support of his opinions and didn't even single out Dr. Arnold with his criticisms in his report. Nevertheless, he will presumably opine at trial:

- Bactrim-Induced Meningitis "is part of the core fund of knowledge of an Infectious Disease Physician;"
- It was below the standard of care for the "Infectious Disease team" to fail to recognize the association between Bactrim and aseptic meningitis and advise Justin Smith of this; and
- Justin Smith's death resulted from Bactrim-Induced Meningitis as a result of his immune system being "primed" by prior Bactrim usage.

Despite failing to identify any authority in their CR 26 disclosures, in written discovery, Plaintiffs have since listed fifty-five (55) articles, journals, books, pamphlets or other publications that they intend to assert as authorities, relating to the medical issues in this case and specifically the diagnosis and treatment of Drug-Induced Aseptic Meningitis ("DIAM") and Bactrim-Induced Meningitis ("BIM"). With respect to at least the first 43 of these materials – six textbooks and 35 other materials identified in Plaintiffs' Second Set of Supplemental Answers served August 31, 2021 – Plaintiffs confirm that they reported no

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cases of death resulting from BIM. *See* Plaintiff's Responses to Requests for Admissions, Exhibit C.

Dr. Brad Spellberg will rebut Dr. Armitage's opinions on behalf of the Defendants. Dr. Spellberg is the Chief Medical Officer at the Los Angeles County-University of Southern California Medical Center, a professor at USC, and an attending infectious disease physician at UCLA Medical Center. He will opine that Dr. Arnold met the standard of care. Dr. Arnold's diagnosis of culture-negative meningitis was reasonable under the circumstances. BIM is rare. There is no test for it. It is unreasonable to expect an infectious disease doctor to recall from memory every drug that could cause meningitis, particularly when there was a reasonable diagnosis and a treatment plan *that successfully addressed the patient's condition*.

Moreover, there is no published medical literature that has identified a patient death due to Bactrim-Induced Meningitis.[4] On the eve of trial, Plaintiffs have attempted to rely on data from the FDA Adverse Event Reporting System to counter this fact, although that source does not conclusively establish that patients have died from ingestion of Bactrim, either. Indeed, one article produced by Plaintiffs shows patients were "rechallenged" with Bactrim (receiving it again after having had an aseptic meningitis reaction) multiple times with no reported death from BIM. Jacqueline S. Marinac, *Drug- and Chemical- Induced Aseptic Meningitis: A Review of the Literature* at p. 817 (*Annals of Pharmacotherapy*, 1992 June, Vol. 26) (Exhibit E).

[4] This is evidenced by the literature Plaintiffs have produced in this case. *See* Jha et al., *A Rare Complication of Trimethoprim-Sulfamethoxazole: Drug Induced Aseptic Meningitis* (Case Reports in Infectious Disease, 2016); Bai et al. *Drug-Induced Aseptic Meningitis: An Uncommon, Challenging Diagnosis* (MDMag.com 2007).

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I. Issues of Fact

A. Was Dr. Arnold negligent?

A medical practitioner has a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which the provider belongs, acting in the same or similar circumstances. *Andrew v. Begley*, 203 S.W.3d 165, 170 (Ky. App. 2006) (*quoting Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970)). The presumption of negligence is never indulged from the mere evidence of mental pain and suffering of the patient, or from failure to cure, or from poor or bad results. *Id.* (*quoting Meador v. Arnold*, 94 S.W.2d 626, 631 (Ky. 1936)). The burden of proof is upon the Plaintiffs to prove the negligence of the practitioner, and that such negligence was the proximate cause of the injury and damages. *Id.*

a) Did Dr. Arnold exercise the same degree of skill and care as a reasonable physician under similar circumstances?

Dr. Arnold's treatment of Justin Smith met the standard of care. There will be expert proof, as detailed above, that Dr. Arnold's care and treatment of Justin Smith was reasonable.

b) Was the alleged breach of the standard of care a substantial factor that caused Justin Smith's death?

To be a legal cause of another's harm, it is not enough that the harm would not have occurred had the actor not been negligent. *Deutsch v. Schein*, 597 S.W.2d 141, 144 (Ky. 1980). The negligence must also be a substantial factor in bringing about the harm. *Id.* The word "substantial" is used to denote the fact that the defendant's conduct has such an effect in producing the harm as to lead reasonable [people] to regard it as a cause. *Id.*

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II. Issues of Law

A. *If the jury finds for Plaintiffs regarding Dr. Arnold's negligence, is ULP vicariously liable for Dr. Arnold?*

Defendants do not dispute that Dr. Arnold was acting in the course and scope of his ULP employment when he provided care to Justin Smith. Accordingly, this is a matter of law, and need not be submitted to the jury.

B. *If the jury finds for Plaintiffs, did Dr. Arnold act in reckless disregard for the lives, safety or property of others, including Justin Smith, so as to entitle Plaintiffs to punitive damages?*

Plaintiffs state that they seek $3 million for punitive damages in this matter. Under Kentucky law, punitive damages are only permitted in certain, limited circumstances that are not present here. Specifically, punitive damages are permitted under Kentucky statute only upon a clear and convincing showing that the defendant acted with "oppression, fraud or malice"; and are only permitted under Kentucky common law upon a showing of "gross negligence". Punitive damages are not authorized where a defendant has engaged in inadvertence, mistake, errors of judgment, or ordinary negligence. RESTATEMENT (SECOND) OF TORTS § 908 cmt. B (1979). Under Kentucky statute (KRS 411.184):

- "Oppression" is defined as "conduct which is specifically intended by the defendant to subject the plaintiff to cruel and unjust hardship";
- "Fraud" is defined as an "intentional misrepresentation, deceit, or concealment of material fact known to the defendant and made with the intention of causing injury to the plaintiff"; and
- "Malice" means "either conduct which is specifically intended by the defendant to cause tangible or intangible injury to the plaintiff or conduct that is carried out by the defendant both with a flagrant indifference to the rights of the plaintiff and with a subjective awareness that such conduct will result in human death or bodily harm".

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Id. Gross negligence requires more than a failure to exercise ordinary care; it requires a finding of a failure to exercise even slight care, such as to demonstrate a wanton or reckless disregard for rights of others. *Phelps v. Louisville Water Co.*, 103 S.W.3d 46, 51-52 (Ky. 2003).

The distinguishing characteristic in cases where punitive damages are authorized is "whether the misconduct 'has the character of outrage.'" *Id.* at 389 (*citing Hensley v. Paul Miller Ford Co., Inc.*, 508 S.W.2d 759, 762 (Ky. 1974)). The threshold for punitive damages is "misconduct involving something more than merely commission of the tort". *Blue Sky Inc. v. Millers Lane Ctr., LLC,* 2020 WL 4500590 (Ky. App. July 17, 2020) (copy of case attached as Exhibit F) (*quoting Fowler v. Mantooth,* 683 S.W.2d 250, 252 (Ky. 1984)). The "something more" is "conscious wrongdoing" or malice. *Id.* Malice may be implied from outrageous conduct so long as the conduct is sufficient to evidence "conscious wrongdoing." *Id.*

Dr. Arnold cared for Justin at ULH, visiting on the second day of his Second Meningitis admission, and every day thereafter until his discharge. Dr. Arnold adjusted Justin's antibiotics, and he ordered additional diagnostic studies, trying to diagnose a specific cause of Justin's meningitis – a goal that even Plaintiffs' expert, Dr. Armitage, agrees is not always possible.[5] As a result of Dr. Arnold's thoughtful treatment, Justin's condition rapidly (and fully) improved. Clearly, Dr. Arnold exercised more than "slight care" for Justin.

Plaintiffs' primary allegation is that Dr. Arnold breached the standard of care through his "failure to know" that Bactrim could potentially cause a patient to experience meningitis, and his related failure to have that condition in his differential diagnosis regarding Justin

[5] Dr. Armitage Depo. at p. 142 (Exhibit G).

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Smith's presentation in June 2016.[6] Dr. Arnold testified that he was never taught about this condition, at medical school, or in his residency or fellowship.[7] Similarly, Dr. Bryant (another board-certified infectious disease physician) was unaware of this condition when she treated Justin in 2005, until a colleague "educated" her about it.

It is difficult to comprehend how a defendant's "failure to know" something they were not taught can be considered "conscious wrongdoing." It is doubly difficult to comprehend how it can be considered "outrageous conduct" for a defendant not to know about an extremely rare condition, which others who are similarly situated (other board-certified infectious disease physicians) also do not know. Punitive damages are "given to the plaintiff over and above the full compensation for his injuries, for the purpose of punishing the defendant, of teaching him not to do it again, and of deterring others from following his example." *MV Transp. v. Allgeier*, 433 S.W.3d 324, 338 (Ky. 2014) (*quoting Hensley v. Paul Miller Ford, Inc.*, 508 S.W.2d 759, 762 (Ky. 1974)).[8] Most of all, it is difficult to see how "punishing" someone for failing to know something (which they testified they were not taught) could deter that individual – or anyone else – from the "misconduct" of "not knowing" something else in the future. This is not the purpose which punitive damages are intended to serve in Kentucky.

[6] While Plaintiffs also claim that Dr. Arnold breached the standard of care by not obtaining records from Justin's 2005 admission to KCH, and by not instructing Justin not to take Bactrim in the future, these allegations are derivative of Plaintiffs' main argument that Dr. Arnold was at fault for not considering potential Bactrim induced aseptic meningitis in the first place.
[7] Dr. Arnold Depo. at p. 112 (Exhibit H).
[8] Please see, also, *Horton, supra* at 390 (the doctrine of punitive damages "survives because it continues to serve the useful purposes of expressing society's disapproval of intolerable conduct and deterring such conduct where no other remedy would suffice'") (*citing* Mallor & Roberts, *Punitive Damages Toward a Principled Approach*, 31 Hastings L.J. 639, 641 (1980)).

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An instruction of punitive damages is only warranted where the plaintiff presents evidence that specifically supports such an award; and the standard for punitive damages is "stringent." *Shortridge v. Rice*, 929 S.W.2d 194, 197 (Ky. App. 1996); *Est. of Embry v. Geo. Trans. of Indiana, Inc.*, 478 S.W.2d 914 (Ky. 2007). Kentucky law reserves a claim of punitive damages to situations where there is egregious behavior and "truly gross negligence." *Kinney v. Butcher*, at 359. Punitive damages "may be *awarded for conduct that is outrageous*, because of the defendant's evil motive *or* his reckless indifference to the rights of others". *Horton, supra* at 389. At most, even if Plaintiffs prove all their allegations in this case, there is no evidence that Dr. Arnold's medical care constitutes the kind of egregious behavior, conscious wrongdoing, or misconduct that is deserving of the "punishment" intended by punitive damages under Kentucky law. A punitive damages instruction in this case would eliminate the distinction between claims of ordinary negligence and gross negligence. *Please see, generally, Kinney, supra.* No punitive damages instruction should be submitted to the jury with respect to Defendant Dr. Forest Arnold.

C. *If the jury finds for Plaintiffs with regard to Dr. Arnold's gross negligence, did ULP authorize, ratify, or should ULP have anticipated the conduct in question?*

Under KRS 411.184(3), punitive damages cannot be assessed against a principal or employer "for the act of an agent or employee unless such principal or employer authorized or ratified or should have anticipated the conduct in question." Per KRS 411.184(2), Plaintiffs must prove by *clear and convincing evidence* not only that the employee was grossly negligent, but also that the employer's conduct satisfies the requirements of KRS 411.184(3).

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Plaintiffs will argue ULP "ratified" Dr. Arnold's conduct.[9] For the imposition of punitive damages, "an employer's ratification of an employee's offensive conduct requires two elements: 1) an after-the-fact awareness of the conduct; and 2) an intent to ratify it." *Saint Joseph Healthcare, Inc. v. Thomas*, 487 S.W.3d 864, 874 (Ky. 2016). Kentucky is the only state with a statute that so broadly limits vicarious liability for punitive damages. *Berrier v. Bizer*, 57 S.W.3d 271, 283 (Ky. 2001). Although KRS 411.184(3) permits a court to impose liability upon an employer for the actions of an employee, "it also imposes significant limits on that liability." *Dean v. Pike Elec. Co.*, 2013 WL 2009900 at *1 (W.D. Ky. May 13, 2013) (*citing McGonigle v. Whitehawk*, 481 F.Supp.2d 835, 841-42 (W.D. Ky. 2007) for the proposition that "Very few cases on record have recognized vicarious liability for punitive damages"). The Kentucky Supreme Court has only allowed vicarious liability for punitive damages "when the employer was aware that the employee had previously engaged in similar unacceptable behavior or when the employer condoned the wrongful action taken by the employee." *Jones v. Blankenship,* 2007 WL 3400115 at *3 (E.D. Ky. Nov. 13, 2007) (*citing Estate of Presley v. CCS of Conway,* 2004 WL 11799448 (W.D. Ky. May 18, 2004)).

In *University Medical Center v. Beglin*, 375 S.W.3d 783, 794-95 (Ky. 2011), the Supreme Court of Kentucky provided guidance as to how the KRS 411.184(3) factors should be applied. "Ratification" is, in effect, after-the-fact approval of the conduct. As the Kentucky Court of Appeals discussed in *Big Spring Assembly of Good, Inc. v. Stevenson*, the RESTATEMENT (THIRD) OF AGENCY § 4.01 (2006) sets forth a more thorough definition of ratification:

> (1) Ratification is the affirmance of a prior act done by another, whereby the act is given effect as if done by an agent acting with actual authority.

[9] There is no indication that Plaintiffs claim ULP "should have anticipated" Dr. Arnold's conduct.

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(2) A person ratifies an act by

(a) manifesting assent that the act shall affect the person's legal relations, or

(b) conduct that justifies a reasonable assumption that the person so consents.

(3) Ratification does not occur unless

(a) the act is ratifiable as stated in § 4.03,

(b) the person ratifying has the capacity as stated in § 4.04,

(c) the ratification is timely as stated in § 4.05, and

(d) the ratification encompasses the act in its entirety as stated in § 4.07.

Id. at *7. To ratify employee misconduct, an employer must have full knowledge of the material facts surrounding the misconduct and intention to ratify same. *Id.* (*citing Papa John's Int'l Inc. v. McCoy*, 244 S.W.3d 44 (Ky. 2008) and RESTATEMENT (THIRD) OF AGENCY § 4.06 (2006)).

As the Court recognized in *Beglin,* the verb "to ratify" means "to approve and sanction formally: confirm (ratify a treaty)." *Id.* at 794. An employer cannot be regarded as having ratified conduct of its employees simply by denying that the conduct occurred or by mounting a legal defense against claims arising from the conduct. *St. Joseph Healthcare, Inc. v. Thomas*, 487 S.W.3d 864, 874 (Ky. 2016). Moreover, retention of an employee without reprimand following wrongdoing does not amount to ratification. *Patterson v. Tommy Blair, Inc.*, 265 S.W.3d 241 (Ky. App. 2007). Even where a podiatrist began operating on the wrong foot, hospital administration permitted him to continue with the correct foot after the mistake was discovered, and an "allegedly shoddy investigation" which was "lackadaisical at most" took place, this is not ratification. *Griffey v. Adams*, 2018 WL 3118185 (W.D.Ky. June 25,

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2018) (*please see, also, Beglin, supra* in which a poor quality investigation did not amount to approval of the conduct). Indeed, it is "very difficult to obtain punitive damages against an employer for the negligent acts of its employees." *Jones, supra* at *4. Indeed, in the few cases in which this has occurred, the facts were truly egregious and showed not only knowledge, but active post-event involvement by the employer that clearly equated to ratification.[10]

The proof in this case will not support a finding that ULP "ratified" any alleged tortious conduct by Dr. Arnold under these standards of Kentucky law. As such, Defendants submit that no punitive damages instruction with regard to ULP should be submitted to the jury.

DAMAGES

The evidence will show that Justin Smith had a history of uncontrolled seizures that led to serious motor vehicle accidents. In the first such accident April 2007, his infant daughter died. The child's mother, Kendra, married Justin eleven days later. Approximately

[10] in *St. Joseph, supra*, the estate of a decedent (who was diseased, paraplegic, uninsured and indigent) sued a hospital and ER staff after he was repeatedly discharged when he presented with abdominal pain, nausea, vomiting, and severe constipation; after his final discharge, he was warned that he would be arrested if he returned. He refused to go back to the hospital and died. The Supreme Court found that the proactive nature of the concerted effort to keep decedent away over a period of 16 hours supported a reasonable inference that the hospital's management was aware of what was happening, and although they did not authorize it, they ratified it. In *MV Transp., Inc. v. Allgeier*, 433 S.W.3d 324, 338 (Ky. 2014), a wheelchair-bound passenger sued the company responsible for her paratransit bus service after she fell due to misalignment of the wheelchair lift with such force that the femur of both legs splintered, causing her extraordinary pain. Rather than care for her injuries, the company spent their taking photographs of the scene and sequestering the driver to follow its policy of guarding against "fraudulent and excessive liability claims". For over 20 minutes, the plaintiff was lying in intense pain on the metal lift in sub-freezing weather covered only with a thin blanket a nearby resident had brought to her. The Supreme Court of Kentucky found that under these facts, the company "placed its own financial self-interests ahead of [the plaintiff's] urgent need for medical assistance." *Id.*

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one month after they were married, Kendra became pregnant with their second child. They would go on to have two more children together.

According to Kendra, Justin did not drive for several years after their daughter's death in 2007.[11] She believes he obtained his license again in 2015.[12] However, records from the Hardin Memorial Hospital show that Justin was involved in another single-vehicle accident on February 12, 2014.

Despite his history of seizures and accidents, Justin continued to drive. On April 20, 2016, he had the serious crash that started the chain of events that led to this lawsuit. In this accident, he had *just dropped off his youngest child* and was on his way to work.[13] He was driving with a suspended license because he lacked a medical review.

In this case, Plaintiffs seek damages of the three children's loss of parental consortium, Kendra's loss of spousal consortium, and damages for Justin's lost earnings.

I. Issues of Fact

A. *If the jury finds for Plaintiffs, have Justin Smith's surviving children sustained, or are they reasonably certain to sustain in the future, a loss of love, care, and protection as a result of the death of Justin Smith?*

In *Giuliani v. Guiler*, the Kentucky Supreme Court recognized the claim of minor children for loss of parental consortium. 951 S.W.2d 318, 319 (Ky. 1997). The Court held that the claim recognizes "[T]he necessity for protection by the law of the parent's love, care and protection so as to provide for the complete development of [the] child." *Id.* at 320

[11] Kendra Smith Depo., 3/27/18, at p. 50 (Exhibit I)
[12] Kendra Smith Depo. at p. 50 (Exhibit I).
[13] The police report states "kids" (plural). Kendra Smith confirmed, at her deposition, that Justin had dropped off their youngest son, Owen, at the baby-sitter's home prior to the accident. (Kendra Smith Depo, 3/27/18, p. 59) (Exhibit I).

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(emphasis added). The jury will have to decide from the evidence the value of Justin Smith's "care and protection" of his children.

B. *If the jury finds for Plaintiffs, has Kendra Smith sustained, or is she reasonably certain to sustain in the future, a loss of services, assistance, aid, companionship, and conjugal relationship as a result of the death of Justin Smith?*

Under KRS 411.145, a spouse may recover for the loss of "services, assistance, aid, society, companionship and conjugal relationship." Approximately 18 months after Justin's death, Kendra moved her children to Alaska. According to counseling records, she was in a relationship there with a man who had four children of his own. The man and his children stayed with her and her children (a situation that her children reported to the counselor). In early 2018, Kendra returned to Kentucky and began dating Aaron Seybert. She became pregnant in May of 2018. They married on January 9, 2019. They have had two baby daughters together.

From every indication, Kendra and Aaron are very happily married. Kendra's three sons now live with Aaron. They call him "Dad."[14]

[14] Aaron Seybert Deposition, 6/1/22, at p. 88 (attached as Exhibit J).

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See Exhibit 8 to Seybert Depo. (attached as Exhibit J).

If the jury finds for Plaintiffs, it will be charged with valuing the loss of Kendra and Justin's marital relationship. Pending before the Court is a motion to limit these damages to the date of Kendra's marriage to Aaron Seybert.

C. *If the jury finds for Plaintiffs, has Justin Smith's Estate sustained a loss due to the destruction of Justin's power to labor and earn money?*

If the jury finds that Dr. Arnold was negligent in his medical treatment of Justin Smith, the jury may also consider whether the Estate has sustained a loss due to the destruction of Justin's power to labor and earn money. Defendants dispute this element of damages. Any testimony regarding Justin Smith's lost earning capacity is purely speculative. Plaintiffs' expert, Dr. Baldwin, has cherry-picked certain information about Justin's educational and employment history to calculate predicted lost earnings of $2.9 million. He has ignored relevant evidence that undermines his opinion. Defendants intend to present this evidence to the jury.

D. *If the jury finds for Plaintiffs, can Justin Smith's Estate recover for his funeral and burial expenses?*

In Plaintiffs' Second Amended Damages Itemization (filed June 30, 2022), Plaintiffs stated that they would seek at trial "Funeral and Burial Expenses" in the amount of $10,000.00. To date, it does not appear that Plaintiffs have produced any invoices, bills, receipts, or any other documentation to support this claim. Without such documentation to support this claim, they cannot recover this element of damage at trial.

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II. Issues of Law

A. *If the jury finds for Plaintiffs, can Justin Smith's Estate recover for his pain and suffering during his hospital admission from June 26 to 29, 2016?*

In their Second Amended Damages Itemization (filed June 30, 2022), Plaintiffs state that they will seek the amount of $1 million for pain and suffering on behalf of Justin Smith's Estate. Defendants do not dispute that when Justin Smith arrived in the ULH emergency department on the morning of June 26, 2019, he was alert (although agitated and confused). Justin's father testified that he never observed Justin to have any level of consciousness after being transferred into the ICU on the evening of June 26, 2016.[15] By 4:30 am the next morning (June 27, 2016), a nurse had noted that Justin's pupils had become fixed and dilated. A physician confirmed this finding, and a neurosurgery provider determined that he had no brainstem reflexes (this was confirmed with imaging and additional examinations).

Kentucky law permits the recovery of damages for "conscious pain and suffering". *Vitale v. Henchey*, 24 S.W.3d 651 (Ky. 2000). There can be no award for pain and suffering during a state of unconsciousness, as pain must be experienced for such an award. *Sand Hill Energy, Inc. v. Ford Motor Corp.*, 83 S.W.3d 483, 502 (Ky. 2002) (vacated on other grounds) (*quoting* 22 Am.Jur.2d *Damages* § 241 (1988). Here, Justin was conscious until the nurse's examination at 4:35 am, in which she detected that his pupils had become fixed and dilated (findings consistent with brain death). Therefore, any claim for pain and suffering damages on behalf of the Estate should be limited to the time prior to this finding.

[15] Mike Smith Depo. at p. 108 (Exhibit K)

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B. *If the jury finds for Plaintiffs, should any spousal consortium damages terminate at the date of Kendra Smith's remarriage?*

In Kentucky, spousal consortium is defined based on the "emotional and physical elements of a relationship between husband and wife." KRS 411.145. The statute only allows a spouse to recover for the loss of these elements. As of January 9, 2019, Ms. Smith-Seybert is no longer without these elements. Defendants have a pending motion in limine on this issue. Under Kentucky law, the surviving spouse's remarriage should terminate the spousal consortium claim.

Respectfully submitted,

/s/ Timothy H. Napier

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CERTIFICATE OF SERVICE

On August 10, 2022, I electronically filed the foregoing with the Clerk of Court by using the Kentucky Court of Justice eFiling website, which will send a Notice of Electronic Filing and a hyperlink to the electronic document to all eFilers associated with the case. I hereby rely upon Section 12(1) of the eFiling Rules of the Court of Justice which provides that transmission of a hyperlink to the electronic document constitutes service under CR 5. I further certify that the foregoing has also been sent via email to the following counsel:

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