

Please Read Instructions on Reverse Side of Yellow copy

Please print in ink or type

D1.

BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas

Mr.
 Mrs. Kenny & Pamela Metheny, individually,
 Ms. and as Co-Conservators and next friend
 Miss of Cody Metheny, a minor Claimant

vs.

State of Arkansas, Respondent
University of Arkansas for Medical Sciences
Kenny & Pamela Metheny, individually
and as Co-Conservators and next friend
of Cody Metheny, a minor

Do Not Write in These Spaces
Claim No. 12-0196-CC
Date Filed September 2, 2011
(Month) (Day) (Year)
Amount of Claim \$?
Fund UAMS

Negligence/Personal Injury

14703 White Oaks Lane, Mabelvale

COMPLAINT

(Name) the above named Claimant, of 7500 West 40th Street Little Rock
(Street or R.F.D. & No.) (City)

Arkansas 72206 72103 County of Pulaski represented by Duncan Firm
(State) (Zip Code) (Daytime Phone No.) (Legal Counsel, if any, for Claim)
900 S. Shackleford Three Financial Centre Ste. 725 LR AR 72211 (501) 228-7600
1100 Main Street Ste. 2930 Kansas City, MO 64196 (816) 421-1600 says:

State agency involved: University of AR for Medical Sciences Agency sought: ?

Month, day, year and place of incident or service: on or about August 2, 2004

Explanation: See Attached Complaint

ARKANSAS STATE
CLAIMS COMMISSION

SEP 02 2011

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As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof?

Yes; when? October 31, 2005; to whom? Dr. I. Dodd Wilson, Chancellor of UAMS
(Yes or No) (Month) (Day) (Year) (Department)

and that the following action was taken thereon: No action Taken

and that \$ N/A was paid thereon: (2) Has any third person or corporation an interest in this claim? Yes; if so, state name and address

Blue Cross Blue Shield (address not known at this time)
(Name) (Street or R.F.D. & No.) (City) (State) (Zip Code)

and that the nature thereof is as follows: Medical benefits paid

and was acquired on Unknown in the following manner:

Unknown

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

KENNY & PAM METHENY
(Print Claimant/Representative Name)

Kenny & Pam Metheny
(Signature of Claimant/Representative)

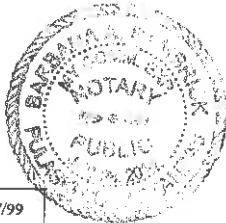
SWORN TO and subscribed before me at Little Rock Arkansas
(City) (State)

on this 2ND day of SEPTEMBER, 2011
(Date) (Month) (Year)

Barbara Bambrick
(Notary Public)

My Commission Expires: 01 28 2014
(Month) (Day) (Year)

(SEAL)



SFI- R7/99

SEP 02 2011

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BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas

PAMELA and KENNY METHENY,
Individually, and as Co-Conservators
for CODY RYAN METHENY

Claimants,

v.

UNIVERSITY OF ARKANSAS FOR
MEDICAL SCIENCES, UAMS

Respondent

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Claim No. _____

VERIFIED COMPLAINT

Claimants, by and through their counsel, for their Verified Complaint, state as follows:

1. Claimants bring this Administrative Claim against the Respondent, University of Arkansas Medical Sciences, UAMS, a state institution and division of the University of Arkansas system. An original claim was filed on July 31, 2006 and voluntarily dismissed by Claimants pursuant to a Claims Commission Order, on September 10, 2010. Claimants bring this claim pursuant to A.C.A. § 16-56-126 within one year of the voluntary non-suit.

2. Claimant Pamela Metheny is a citizen and domiciliary of the State of Arkansas. Mrs. Metheny resides in Pulaski County. She brings this claim in her individual capacity and as a co-conservator for her son Cody Ryan Metheny.

3. Claimant Kenny Metheny is a citizen and domiciliary of the State of Arkansas. Mr. Metheny resides in Pulaski County. He brings this claim in his individual capacity and as a co-conservator for his son Cody Ryan Metheny.

4. Cody Ryan Metheny presently resides part-time in a neuro-rehabilitation facility in Virginia. His parents, Pam and Kenny Metheny, were appointed co-conservators for Cody Metheny on April 21, 2008 by the Circuit Court of Pulaski County, Probate Division. See Order, attached hereto as Exhibit "1" and incorporated herein by reference.

2

5. UAMS is a division of the University of Arkansas. UAMS was involved in the care of Cody Ryan Metheny at Arkansas Children's Hospital ("ACH"). UAMS and ACH have been affiliated by formal agreement and by relationship since 1982. The affiliation is contractual and administratively through course of medical performance is an alter-ego relationship for pediatric patient care. UAMS represents, relates and holds ACH out to the public as its pediatric affiliate in the State of Arkansas.

6. ACH is the Arkansas teaching and residency hospital for treatment of children by UAMS. As such, UAMS faculty members/doctors, Chiefs of professional services and professional staff administratively function under its' affiliate and alter-ego ACH performing the professional conduct of the State's children's hospital. Hospital physicians, patient care professionals, quality assurance and medical records personnel, acting for and on behalf of UAMS's Department of Pediatrics ACH offers a wide range of pediatric medicine programs caring for more than 10,000 inpatient admissions. UAMS affiliate and alter-ego for treatment of children ACH treated Cody Metheny. In this case, UAMS Physician teacher and department head, Dr. Adada, was the Chief of Pediatric Neurosurgery at UAMS's pediatric affiliate and alter-ego ACH at the time Cody Ryan Metheny was treated.

7. Administratively, UAMS, through its pediatric affiliate and alter ego ACH, operated on Cody Ryan Metheny on August 2, 2004, to remove a right-sided brain lesion. This surgery was performed during a teaching and residency neurosurgery program and pursuant to UAMS Administrative/ACH contract affiliation. Cody's brain was operated on the wrong side of the brain. There was extensive damage and tissue removed on the wrong side of the brain. After the multiple hour surgery on the wrong side of the brain, the patient was turned over, re-prepped and, even though contra-indicated, surgery took place on the other side of his brain thereby damaging similar areas on both sides of Cody's brain. Cody had brain tissue removed from the amygdala and hippocampus area on both hemispheres of his brain during these multiple brain surgeries. It is universally medically accepted that removing brain tissue on both sides of the brain should never be done and will in high likelihood cause serious and permanent disability. In particular, removal of this area of the brain will cause and did cause loss of enjoyment of life, cognitive loss, loss of natural drive, memory problems, emotional problems, psychotic

behavior, hallucinations and other psychotropic events and episodes. The injuries caused by the wrong-sided surgery have resulted in Cody having to be cared for in an institutional setting.

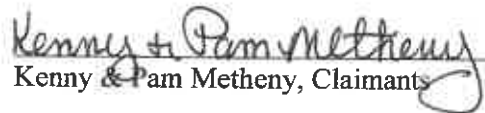
8. UAMS and its pediatric affiliate and alter-ego ACH failed to provide timely and truthful information about the wrong-sided surgery. During the brain surgeries, medical records were created with inaccurate information. The truth behind the multiple surgeries was not revealed or disclosed to Cody's parents, Pam and Kenny Metheny for over one year. The case went to jury trial in Pulaski County, Arkansas with a verdict for \$20 million in favor of the Claimants on September 24, 2010 and against ACH solely for the actions of ACH. Attorneys for the pediatric affiliate ACH are currently appealing this verdict. ACH argues on appeal that ACH's amount of insurance is \$9 million less than the verdict amount. Plaintiffs argue there is sufficient insurance for the pediatric affiliate ACH to cover the \$20 million verdict for injuries to Cody. This Administrative Claim concerns the medical errors performed by ACH, which are imputed to UAMS, its parent administrative government entity, pursuant to their formal affiliation. Claimants respectfully request this matter be stayed pending appeal and until all recourse against private insurance is exhausted through the judiciary process. If insurance is sufficient to cover the entire \$20 million verdict, this Administrative Claim will not be pursued.

9. Claimants attach hereto the Pulaski County Circuit Court Amended Complaint, as Exhibit "2" and documentation supporting their Administrative Claim. Prior to filing this claim, a notice of claim and settlement demand was presented to Dr. I. Dodd Wilson, Chancellor for UAMS on October 31, 2005. Ms. Rhonda Thornton, counsel for UAMS, responded to the notice of claim on November 21, 2005. UAMS has made no payment to the claimants. The total amount of the Administrative Claim in its entirety against UAMS has not yet been ascertained and is dependent upon the resolution of the current appeal to the Arkansas Supreme Court. That appeal will determine how much private insurance is available to cover the injuries and damages sustained by Claimants. A portion of medical expenses incurred by the Claimants on August 2, 2004 have been paid by the Claimants' insurance company, Blue Cross/Blue Shield of Alabama.


10. Claimants respectfully request this Administrative Claim be held in abeyance or stayed pending resolution of the current appeal. Claimants further respectfully request that upon resolution of the appeal this Administrative Claim proceed to hearing before the entire Claims Commission.

WHEREFORE, Claimants pray for all relief claimed herein and to which they may be entitled, including compensatory, special and other damages, in an amount to be determined by the State Claims Commission, at a hearing before the entire Claims Commission, and for all other relief deemed equitable, appropriate and just.

Respectfully submitted,


Kenny & Pam Metheny, Claimants

-and-


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IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF CODY METHENY

PGD. NO. 2005-0004

FILED 04/21/2008 8:21:21

Pat O'Brien Pulaski Circuit Clerk

ORDER

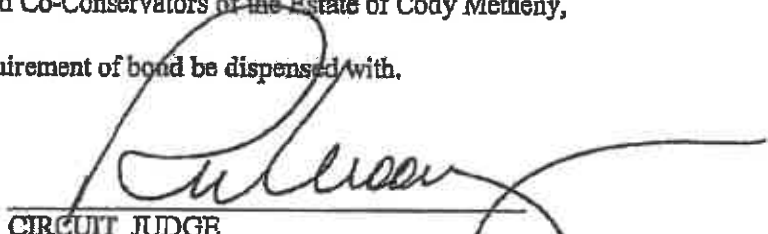
Now before this Court comes to be heard on the verified Petition of Cody Metheny, praying that they be appointed Co-Conservators of the Estate of Cody Metheny, physically disabled from a brain injury as a result of surgeries performed on Cody's brain on August 2, 2004, and after a study of the record and testimony taken, the Court finds:

1. That an estate exists for Cody Metheny.
2. Pam and Cody Metheny are guardians of the estate.
3. That Cody Metheny has reached the age of majority and appointment of a Conservator is necessary for the management of the estate. He is injured physically and continues to experience marked impairment of his capacity to execute business contracts, financial expenditures, property acquisitions and so forth without guidance and assistance. Cody's doctor recommends an individual be appointed to manage his affairs. See letter from Dr. Samuel Boellner, attached hereto as Exhibit "1," and incorporated herein by reference.
4. That Pam and Kenny Metheny are fit and proper persons to act as Co-Conservators for Cody Metheny.
5. That appointment of a Conservator of the estate would be in the best interest of the estate.



6. As authorized in section 28-67-102 *et. seq.* of the Arkansas Code Annotated, the Court finds that it is in the best interest of that Co-Conservators be appointed to manage Cody's Estate.
7. That no bond should be required of the Co-Conservators in their capacity as Co-Conservators of the Estate of Cody Metheny, physically disabled.

IT IS THEREFORE, ORDERED AND ADJUDGED that Pam and Kenny Metheny be and are hereby appointed Co-Conservators of the Estate of Cody Metheny, physically disabled, and that the requirement of bond be dispensed with.



CIRCUIT JUDGE

4/21/08

DATE

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
16th DIVISION

PAMELA and KENNY METHENY,
individually and as co-conservators
of CODY RYAN METHENY

FILED 03/06/2009 13:45:03
Pat O'Brien Palaski Circuit Clerk
CRI By _____

vs.

Case No. CV 09-96

THE MEDICAL ASSURANCE COMPANY, INC.

DEFENDANT

PLAINTIFFS' FIRST AMENDED COMPLAINT

Come now the Plaintiffs, Pamela and Kenny Metheny, individually and as co-conservators of Cody Ryan Metheny, for their First Amended Complaint, state as follows:

I. PARTIES AND DEFINITIONS

1. Plaintiff Pamela Metheny is a citizen and domiciliary of the State of Arkansas. She resides in Pulaski County. Mrs. Metheny sues in her individual capacity and as co-conservator of her son, Cody Ryan Metheny, a physically disabled person.

2. Plaintiff Kenny Metheny is a citizen and domiciliary of the State of Arkansas. He resides in Pulaski County. Mr. Metheny sues in his individual capacity and as co-conservator of his son, Cody Ryan Metheny, a physically disabled person

3. Plaintiff Cody Ryan Metheny ("Cody") is a physically disabled person and is a citizen and domiciliary of the State of Arkansas. He resides in Pulaski County. Pamela and Kenny Metheny, as Cody's co-conservators and parents, bring this lawsuit on his behalf. See Order of Conservatorship for the Estate of Cody Ryan Metheny, attached hereto as Exhibit "1."

4. Pursuant to Ark. Code Ann. § 23-79-210, Defendant The Medical Assurance



Company, Inc., (hereinafter referred to as "Med. Assurance" is a professional liability subsidiary of ProAssurance Corporation, an Alabama Corporation, and is the liability insurance carrier for Arkansas Children's Hospital. The registered agent office of Med. Assurance is P.O. Box 59009, Birmingham, Alabama 35209-0009. The corporate office address for Med. Assurance and ProAssurance Corporation is 100 Brookwood Place, Birmingham, Alabama 35209.

5. Arkansas Children's Hospital ("ACH"), a/k/a Children's Professional Group, holds itself out as a private, not-for-profit health care provider in Little Rock, Arkansas. As such, their charitable status allows the lawsuit to proceed against them without naming them in the style of the case, instead naming their insurance company. This court has previously ruled that ACH should not be the named defendant and Med. Assurance, the insurance carrier for ACH, should be the named defendant. Plaintiffs assert this law of the case as the basis for naming Med. Assurance as the Defendant. However, the direct action statute (as far as the style of the case) does not prevent a judgment over, above and/or outside the insurance coverage for ACH on the causes of action alleged herein that involve both negligent and intentional and/or acts determined by the jury to be outrage. Therefore, Plaintiffs place ACH on notice and their carrier on notice that there may be causes of action alleged herein that can result in money damages being awarded which ACH would be liable because ACH cannot avoid liability for the tort of outrage. Further, upon information and belief, ACH depends on profits and not donations and/or contributions for its existence, and ACH provides its officers and directors considerable compensation for their services. Thus, ACH is a "de-facto" or actual, commercial for-profit enterprise and therefore can be held responsible for damages not covered by insurance.

6. Registered agent for service of process for ACH is Jonathan R. Bates,

President/C.E.O. and Hospital Administrator of ACH at 800 Marshall Street, Little Rock, Arkansas 72202. ACH has retained lawyers by their insured, Med. Assurance, and under Arkansas law this amended complaint can be served upon their lawyers instead of their registered agent.

II. INTRODUCTION

7. This lawsuit concerns serious, progressive, and permanent brain injuries suffered by Cody Ryan Metheny as a result of wrong side brain surgery to the left side of Cody Metheny's brain as well as a second, unauthorized brain surgery to the right side of Cody Metheny's brain. ACH, by and through its administration, employees, department heads, managers, and agents, committed multiple acts of administrative negligence and medical negligence, as well as multiple wrongful and outrageous actions and omissions before, during, and after two brain surgeries on August 2, 2004 while in the scope of their employment and/or agency. Further, upon information and belief, Med. Assurance, by and through its agents and representatives, also committed outrageous acts and omissions which would shock the conscience of the community, including influencing and/or directing the manner in which medical decisions were made for Cody Metheny in order to avoid or limit an insurance claim and/or in anticipation of litigation.

8. One of the alleged goals of the proposed surgery was to eliminate epileptic seizures on the right side of Cody's brain, but after performing a wrong side surgery to the left side of his brain and a second, unauthorized surgery to the right side, ACH caused, among other things, permanent physical, emotional and economic injury to Cody Ryan Metheny and emotional and economic injury to his co-conservators and parents, Pamela and Kenny Metheny.

9. For purposes of this Complaint, the term "surgical team" is defined to include, but

is not limited to the doctors (the neurosurgeon who performed the two surgeries on Cody Metheny, the neurosurgeon resident for ACH who assisted in performing the two surgeries on Cody Metheny; the neurologist for ACH who read the EEG during the surgeries performed on Cody Metheny; the anesthesiologist for ACH who provided anesthesia for surgeries performed on Cody Metheny, the resident anesthesiologist for ACH who assisted the anesthesiologist in the surgeries performed on Cody Metheny, the anesthesiologist fellow for ACH who also assisted the anesthesiologist in the surgeries performed on Cody Metheny), the ACH nurses (four (4) circulating nurses and four (4) Scrub Techs), and other ACH employees (EEG/CNIM tech) named in Cody Metheny's medical records (specifically the "Intraoperative Record" dated August 2, 2004). Members of the surgical team are alleged to be employees and/or agents of ACH.

10. The terms department heads, managers, employees and agents include the ACH administrators, doctors, nurses, and any other personnel acting on behalf of ACH for the care and treatment of Cody Metheny, which further specifically includes the ACH CEO, the ACH Risk Manager, the ACH Senior Vice President of Patient Care, the ACH Chief Nursing Officer, the ACH Vice President of Patient Care, the ACH Director of Surgical Services, the ACH Director of Quality Improvement, and the ACH Nursing Coordinators on duty at ACH during Cody's Metheny stay in August 2004.

11. ACH, by and through its surgical team, removed and destroyed critical brain tissue from both sides of Cody Metheny's brain and failed to document and inform the parents of this fact.

12. ACH, by and through its department heads, managers, employees, and agents, had actual knowledge of the two wrongful surgeries and failed to document and inform the parents of

this fact. Specific allegations are plead below.

13. Once ACH, by and through its surgical team, operated on the wrong side of Cody's brain, ACH did not have the consent of Cody's parents for a second surgery. When faced with the decision to report this wrong side brain surgery to JCAHO (the commission that accredits hospitals in Arkansas and across the United States, which is particularly important for Medicaid and Medicare Reimbursement Standards and State Medical Board requirements in Arkansas), ACH legal counsel advised ACH to not report these incidents to JCAHO or the Arkansas State Medical Board, which is charged with "protecting the people of Arkansas." ACH acquiesced, ratified and agreed to not report what actually happened to the parents.

14. The two wrongful surgeries took place on August 2, 2004; however, the final surgery report ("Operative Note") from Cody's medical records was not written and signed by ACH, by and through a member of the surgical team (neurosurgeon), until 49 days after the surgeries. ACH completed this extremely delinquent and critical medical record late in violation of their policies and procedures . In the words of the ACH CEO, this record was an important document to get "exactly right." In addition, ACH failed to document the wrong side brain surgery in the final surgery report or any other medical record. ACH called their lawyers and Med. Assurance and reported the event to them but did not inform Cody's family what actually happened to Cody, depriving Cody of critical, timely and reasonably necessary medical treatment, continuity of treatment and care and rehabilitation.

15. At the time of the two surgeries, Cody was a 15 year old boy. He has suffered and will continue to suffer catastrophic damage and harm to his brain and his brain's function, including but not limited to areas of his brain that control, among other things, memory, emotion,

and what gives him the ability to grow and develop into an adult. Further, Cody is expected to have a full life expectancy. Specific details of the acts of negligence and outrage as well as damages and harms are set forth below.

III. JURISDICTION AND VENUE

16. This Court has jurisdiction over the parties and subject matter of this lawsuit. Further, venue is proper in Pulaski County where the parties reside; where the medical injuries occurred and where Plaintiffs' claims arose. On May 23, 2008, the Circuit Court, 16th Division, granted Plaintiffs' motion to dismiss without prejudice. The Order is attached hereto as Exhibit "2." This amended complaint is timely filed per Arkansas Rule of Civil Procedure 41.

IV. FACTUAL ALLEGATIONS

A. ACH Background

17. ACH is an affiliate of the University of Arkansas for Medical Sciences ("UAMS"); the two entities entered into an Affiliation Agreement ("Agreement") in January 1982.

18. Pursuant to the Agreement, ACH is a clinical and teaching affiliate of UAMS established, among other things, for the purpose of providing a great advantage to the welfare of children in the state of Arkansas.

19. Pursuant to the Agreement, UAMS physicians and other UAMS employees, while working for ACH, act and perform their duties not only as employees of UAMS, but serve as dual employees of ACH, or alternatively are agents of ACH and functioned as department heads/managers.

20. Pursuant to the Agreement, an inter-institutional committee (hereinafter "IIC") is charged with the responsibility for developing plans and establishing joint operational policies

between the two institutions. Members of the IIC shall include the Executive Committee of the ACH Board, the UAMS Chancellor, the Dean of the College of Medicine, the Hospital CEO, the UAMS Executive Director of Clinical Programs, the Medical Director of ACH, the Chairman of the Department of Pediatrics and the ACH Chief of pediatric Staff.

21. Pursuant to the Agreement, the IIC shall have as its function the overall annual evaluation of the Agreement and shall develop procedures and guidelines as warranted for carrying out these activities.

22. Pursuant to the Agreement, the Chiefs of various professional services shall be selected by the Chairman of the respective Departments of UAMS subject to approval of the Dean and the ACH Board.

23. Pursuant to the Agreement, the ACH Board will appoint and select a CEO to manage ACH. Residents, interns and students assigned to the hospital are responsible to the Chiefs of the ACH services for all professional activities.

24. The CEO of ACH is responsible for carrying out all ACH policies and procedures, as well as formulating and administering ACH policies.

B. Cody Metheny's Medical History and the ACH Surgeries on August 2, 2004

25. At the time of the acts and omissions described below, Cody was a fifteen (15) year old boy who had an epileptic seizure condition that was diagnosed at the approximate age of seven (7) years old. Following Cody's diagnosis with a seizure disorder, he took anticonvulsants (seizure-control medications). Cody's seizure disorder remained well-managed under seizure-control medication until such medication was discontinued, reduced or changed.

26. Cody was admitted to ACH in January 2000 for seizure monitoring to determine if

he could discontinue taking anticonvulsants. Shortly after tapering off of the anticonvulsants, Cody had recurrences of seizures and was placed back on anticonvulsant medication. Cody then remained seizure-free for approximately a three (3) year period until October 2003. During that time period, Cody was again tapered off of anticonvulsant medication. However, because Cody had a reoccurrence of seizures while off the anticonvulsants, he was placed back on the anticonvulsant medication by ACH's neurologist.

27. In December 2003, Cody had another seizure episode which was shortly after the October attempt to discontinue his seizure medication. He was readmitted to ACH for observation and was referred to ACH neurosurgeon for possible seizure surgery.

28. In January 2004, Cody was again readmitted to ACH for video electroencephalogram ("EEG") monitoring to identify the etiology of his seizure disorder and to consider seizure surgery. ACH, by and through their employees and agents (ACH's neurosurgeon for Cody Metheny and ACH's neurologist), saw Cody during this January 2004 hospital stay at ACH. According to ACH records, a magnetic resonance imaging ("MRI") conducted during that time period showed a right temporal lobe lesion. ACH, by and through their employees and agents (ACH's neurosurgeon for Cody Metheny and ACH's neurologist), reviewed Cody's seizure history and current prognosis. Based on the medical records, Cody was not a candidate for brain surgery at that time. Cody was discharged from ACH on January 14, 2004, with the follow-up plan to undergo a subsequent MRI regarding his right temporal lobe lesion within three (3) months.

29. Pursuant to the follow-up plan, Cody underwent an MRI scan and positron emission tomography ("PET") scan in April and May of 2004, respectively. ACH, by and

through their employees and agents (ACH's neurosurgeon for Cody Metheny) conducted the MRI in April 2004. This ACH MRI reading demonstrated an "abnormal signal focus in the mesiotemporal region on the right anteriorly."

30. In June 2004, ACH, by and through their employees and agents (ACH's neurosurgeon who performed the surgeries on Cody Metheny and ACH's neurologist who assisted in the surgeries performed on Cody Metheny), again evaluated Cody for seizure activity and determined that Cody still had a seizure disorder. However, Cody's seizure problem continued to be managed by anticonvulsant medication. Without a documented formal ACH pre-surgical team meeting and decision, ACH, by and through their employees and agents (ACH's neurosurgeon for Cody Metheny and ACH's neurologist) scheduled Cody for elective surgical excision of his right temporal lobe lesion to be performed at ACH.

31. Prior to the surgery to excise the right temporal lobe lesion at ACH, ACH, by and through its neurosurgeon for Cody Metheny, advised Cody's mother, Pam Metheny, that Cody's lesion was in the right temporal lobe and that because Cody was right handed (left brain dominant), the surgery could be performed. But, ACH by and through its neurosurgeon and ACH's neurologist for Cody Metheny, informed Pam that if the seizures originated from the left side, surgery would not be an acceptable alternative because they would not and should not perform surgery on the dominant side of his brain, the left hemisphere.

32. Medical evidence shows that Cody was not a surgical candidate and that his seizures were controlled by anticonvulsants. ACH, by and through their employees and/or agents and representatives (ACH's neurosurgeon and neurologist for Cody Metheny), either knew or should have known that the surgery was unnecessary.

33. The Arkansas Democrat-Gazette was invited by ACH to observe the surgery and to take photographs of the surgical procedure, because ACH wanted to promote this type of surgery to the public at large for advancement of their own business purposes. At the request of ACH, Pam Metheny signed a medical authorization form on Cody's behalf for the release the photographs. As a result of the authorization, the Arkansas Democrat-Gazette took photographs before, during, and after the surgery, some of which were displayed and discussed in published articles.

34. On August 2, 2004, ACH, by and through their employees, agents and the surgical team described above, began to perform surgery on Cody to excise the right temporal lobe lesion. Cody was placed under general anesthesia for brain surgery, which was supposed to occur on his right temporal lobe (right hemisphere).

35. The surgery was scheduled to last approximately four (4) hours. ACH's surgical team draped and shaved Cody's head on the left side instead of the right side of his head.

36. ACH's surgical team then proceeded together as a team to perform a surgery on the left side, which was the wrong side of Cody's brain to excise a right temporal lobe lesion.

37. ACH's surgical team began the surgery on the wrong (left) side of Cody Metheny's brain by making an incision extending from the root of the left zygoma, going behind the hair line into the midline. Raney clips were applied on the left side for hemostasis.

38. ACH's surgical team then performed a subgaleal dissection on the left side, exposing the temporalis muscle.

39. ACH's surgical team then made an incision in the left temporalis fascia, as well as in the temporalis muscle. The left temporalis muscle was elevated in a subperiosteal manner

exposing the root of the zygoma, as well as the left orbital zygomatic suture. Three (3) bur holes were drilled on the left side of Cody's skull, 1 at the keyhole, 1 at the root of the zygoma, and 1 at the junction of the coronal suture over the superotemporal line. A pterional craniotomy was fashioned. The bone flap was elevated. The dura on the left was penetrated and opened on the left (wrong) side.

40. After the dura was penetrated and opened, ACH's surgical team removed and damaged and/or destroyed portions of the left brain including but not limited to amygdala, parts of the hippocampus and other brain tissue from the left side. This was without consent and a breach of the standard of care for ACH's surgical team.

41. After performing surgery on the wrong side of the brain, the ACH surgery team performed an unauthorized and non-consented to surgery on the right brain resulting in bilateral temporal lobe surgery without consent.

C. Additional Breaches of the Standard of Care by ACH

42. The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) required a Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. This protocol was to use a "time-out" just before starting the procedure to allow the entire surgical team to ensure the correct patient, procedure and body part. As early as 2003, JCAHO indentified and made it known that the site and side of the brain should be marked for brain surgery and that failure to mark created an unreasonable risk to the safety of the patient. Further, JCAHO warned that if a Hospital surgical team relies only on the neurosurgeon to verify the site for brain surgery, this was a risk factor for patient safety.

43. ACH adopted JCAHO protocols, including the JCAHO "time-out" protocol, on

March 13, 2004, prior to the incident in question.

44. ACH did not properly follow the JCAHO protocols. Instead, ACH's surgical team wrongfully performed wrong-side and wrong-site surgery (left side of brain) on Cody, causing permanent brain damage.

45. ACH's surgical team performed a selective amygdala hippocampectomy, on the wrong (left) side, which was not documented by ACH's surgery team in any of the medical records.

46. Contrary to the standard of care, ACH's surgical team never obtained consent to proceed with surgery on the left side of Cody's brain. Further, ACH's surgical team never obtained consent to proceed with a second brain surgery on the right side of Cody's brain once the improper left (or wrong) sided surgery had already taken place.

47. At some point during the surgery on the wrong side (hemisphere) of Cody's brain, ACH's surgical team dismissed the media from the operating room without explanation.

48. ACH's employees and agents (ACH's neurosurgeon) then announced in the newspaper to the public through its public relations department that Cody suffered no harm. Even though ACH considered this incident a sentinel event it never treated it as such in violation of their sentinel event policy.

D. The Administrative Failures of the ACH CEO

49. ACH's CEO was present at the Hospital on August 2, 2004 and was aware of the wrong side brain surgery on Cody's left side of his brain while it was still occurring. However, ACH's CEO never intervened, nor requested intervention, before portions of both sides of Cody's brain were removed.

50. ACH's Circulating Nurse who began the pre-surgery preparations on August 2, 2004, who was a member of the ACH surgical team, and who is one of the CEO's links to the surgical team, was not properly trained in "time-out" policy and procedure and failed to follow both ACH and JCAHO protocols. ACH, by and through its Circulating Nurse, did not identify the right (hemisphere) side of the brain as the place surgery was to be performed; did not verify the patient's correct surgical side or site; did not chart the surgery procedures in the medical records; received a portion of the brain identified verbally by ACH's neurosurgeon as the "amygdala" from the left hemisphere (wrong side) of the brain, yet never documented this fact in medical records. This verbal statement by ACH's neurosurgeon concerning the left side of the brain "amygdala" was made in the presence of the surgical team. Therefore, the surgical team knew or should have known brain tissue was taken from the left side of Cody's brain and that it was from the wrong side, because it was announced aloud in the Operating Room that surgery had been performed on the wrong side of Cody's brain. No member of ACH's surgical team documented that brain was taken from the left hemisphere (wrong side) of the brain. Further, no member of ACH's surgical team disclosed to the parents that portions of the brain from the left hemisphere (wrong side) had been wrongfully removed and destroyed in surgery.

51. Even though ACH's CEO, Risk Manager, Senior Vice President of Patient Care and Chief Nursing Officer, Vice President of Patient Care, Director of Surgical Services, and/or Director of Quality Improvement (who are considered employees, department heads, managers, and /or agents of ACH) knew of the wrong side surgery while it was still occurring, but failed to require that the surgical team review Cody's status and condition with the parents prior to a second surgery taking place. Further, ACH agreed, acquiesced and ratified all of the conduct by

the surgery team through its failure to intervene and protect the patient's rights.

52. ACH's managers, department heads, administrators, agents, and/or employees acting on behalf of ACH for the care and treatment of Cody Metheny failed to contact and follow up on and manage Cody's status and condition prior to a second surgery taking place.

53. ACH's managers, department heads, administrators, agents, employees acting on behalf of ACH further failed to perform a formal investigation of the two surgeries. ACH performed no peer review and failed to notify the Arkansas Medical Board.

54. Further, ACH's managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH never reported the wrong-side surgery incident to JCAHO during 2004 and 2005, even though JCAHO conducted a survey of ACH during this time period. As of the date of this Complaint, the wrong side surgery has not been reported to JCAHO or the Arkansas Medical Board by ACH.

55. ACH's managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH also failed to conduct a root cause analysis.

56. ACH, by and through its employees and agents, billed the Methenys for both the wrong side (hemisphere) surgery and the unauthorized surgery on the right temporal lobe.

V. CAUSES OF ACTION

FIRST CAUSE OF ACTION -- DIRECT AND VICARIOUS GENERAL ADMINISTRATIVE NEGLIGENCE OF ACH

57. The facts and allegations recited in paragraphs 1 through 55 are incorporated by reference and made a part hereof as though set out verbatim.

58. ACH, by and through its CEO, Risk Manager, Senior Vice President of Patient

Care and Chief Nursing Officer, Vice President of Patient Care, Director of Surgical Services, and/or Director of Quality Improvement committed administrative negligence by failing to stop the second surgery from taking place after knowing that the wrong side surgery had taken place, and of the dire consequences of removing brain matter from both sides of Cody's brain.

59. ACH, by and through its managers, department heads, administrators, agents, and employees and surgery team acting on behalf of ACH, knew or should have known that the wrong side surgery had taken place, and of the dire consequences of removing brain matter from both sides of Cody's brain.

60. ACH, by and through its managers, department heads, administrators, doctors, agents, employees and surgery team acting on behalf of ACH failed to inform or communicate with Plaintiffs during or after the surgery about what actually happened to the left hemisphere of Cody's brain.

61. ACH, by and through its managers, department heads, administrators, agents, and employees acting on behalf of ACH, was therefore administratively negligent by:

a) failing to hire, place, staff, grant surgery privileges to, and otherwise provide duly qualified and adequately trained physicians, interns, residents, nurses, technicians, and other medical, support personnel and care providers, so as to provide adequate care to the patients who entrust themselves to the care of ACH;

b) failing to properly implement and follow the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery;

c) failing to ensure adequate precautions and adopt proper hospital, surgical,

and operating procedures;

d) failing to properly train their nurses, care providers, technicians, residents, managers, department heads, administrators, agents, employees and surgery team in the proper policies and procedures to meet surgical, medical, monitoring and supervisory needs of Cody;

e) failing to train their nurses, care providers, technicians, care providers, and managers, department heads, administrators, agents, employees and surgery team as to proper policies, precautions and procedures for caring for patients requiring surgery such as the one performed on Cody;

f) failing to properly supervise the acts and/or omissions of their managers, department heads, administrators, agents, and employees and surgery team;

g) failing to otherwise adopt and/or follow policies and procedures which could have been reasonably expected to ensure proper patient treatment, communication, monitoring, and supervision for patients requiring surgery such as the one performed on Cody;

h) failing to otherwise adopt and/or follow policies and procedures which would ensure that proper, accurate, and complete medical documentation occurred during the care of a patient;

i) failing to disclose the true extent and concealing the wrong side surgery upon Cody's brain to the Plaintiffs, or applicable accreditation entities such as JCAHO or the Arkansas State Medical Board;

j) failing to follow up with all persons involved in the incident to determine how to properly treat Cody during his time at ACH following the surgeries and after he was discharged;

k) failing to conduct an adequate and thorough root cause analysis (but instead called the ACH lawyers to begin formulating their defense of the wrong sided brain surgery);

l) failing to conduct a peer review of the incident;

m) failing to inform JCAHO of the incident;

n) failing to ensure that Cody's medical records were accurate, complete, concise, and objective when they knew or should have known what actually occurred and the real risks and consequences involved in Cody's future medical care should nothing be done to properly document what actually occurred and act upon this information;

o) failing to act as a reasonable hospital, teaching hospital, and/or a reasonable person in the same or similar locality would under the same or similar circumstances; and,

p) generally acting with negligence, imprudence, and lack of expertise under the circumstances.

62. All of the above-described acts and/or omissions were the proximate cause of wrongful injury to Cody and his parents.

63. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, committed negligent acts and omissions and breached its duties of care owed to Cody as a patient. ACH directly and proximately caused Cody's damages and wrongful injuries, including, but not limited to, serious, permanent physical brain injury and injury to his brain's functions, damage to his emotional capacity, damage to his executive functioning skills, weakening of his skull, scarring and disfigurement, past, present and future pain, suffering and mental anguish, humiliation, embarrassment, past, present and future medical expenses and loss of prospective earnings and earning capacity in an amount to be proven

at trial.. ACH has by its negligent acts and omissions aggravated pre-existing injuries enumerated above .

64. As outlined throughout this Complaint, prior to the surgeries performed on August 2, 2004, during the surgeries, and thereafter, Cody was under the care of ACH, by and through its managers, department heads, administrators, agents, neurosurgeon, neurologist, employees and surgery team acting on behalf of ACH. Upon information and belief, all members of administrative management of ACH under its affiliation as a teaching and clinical institution were staff, employees, agents, and/or servants of ACH. All persons or entities under the control of ACH, either directly, or indirectly, including their staff, doctors, employees, agents, and/or consultants, whether "in-house" or outside entities, individuals, agencies, subsidiaries or subalterns, who caused or contributed to the injuries suffered by Cody and his parents and guardians, Pamela and Kenny Metheny, were, at all times relevant to this action, acting under the direct supervisory control of ACH, by and through its managers, department heads, administrators, agents, and/or servants of ACH the conduct of these individuals is imputed to ACH; and ACH is liable for such wrongful conduct under the doctrines of "acting in concert", "joint venture", "joint and several liability" and/or vicarious liability.

**SECOND CAUSE OF ACTION
MEDICAL NEGLIGENCE OF ACH FOR THE FIRST SURGERY (COUNT I)
AND FOR THE SECOND SURGERY (COUNT II)**

65. The facts and allegations recited in paragraphs 1 through 63 are incorporated by reference and made a part hereof as though set out verbatim.

66. At all times, ACH held itself out to the public as a competent and skillful medical institution providing patient care in Little Rock, Arkansas. ACH had a duty to possess and apply

the applicable standard of care of similar institutions. Further, ACH held itself out to have an internationally renowned reputation using nationally recognized standards of medical practice.

67. In diagnosing the condition, treating, operating, re-operating a second time, and/or failing to obtain the necessary consent, ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, failed to possess and apply with reasonable care the degree of skill and learning as well as the applicable standard of care of their professions.

68. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, committed negligent acts and omissions and breached its duties of care owed to Cody as a patient. ACH directly and proximately caused Cody's damages and wrongful injuries, including, but not limited to, serious, permanent physical brain injury and injury to his brain's functions, damage to his emotional capacity, damage to his executive functioning skills, weakening of his skull, scarring and disfigurement, past, present and future pain, suffering and mental anguish, humiliation, embarrassment, past, present and future medical expenses and loss of prospective earnings and earning capacity in an amount to be proven at trial. ACH has by its negligent acts and omissions aggravated pre-existing injuries enumerated above.

69. Prior to the surgeries performed on August 2, 2004, during the surgeries, and thereafter, Cody was under the care of ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH. All members of the surgical team were staff, employees, agents, and/or servants of ACH. All persons or entities under the control of ACH, either directly or indirectly, including their staff, were employees,

agents, consultants, whether “in-house” or outside entities, individuals, agencies, subsidiaries, or subalterns, who caused or contributed to the injuries suffered by Cody and his parents were, at all times relevant to this action, acting under the control of ACH and the conduct of these individuals is imputed to ACH; and ACH is liable for such wrongful conduct under the doctrines of agency, “respondeat superior”, “acting in concert,” “joint venture,” “joint and several liability” and/or vicarious liability.

70. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, breached the applicable standard of care by actively planning, performing and completing two separate and complete craniotomies on Cody’s brain. The two surgeries are separate, distinct and independent medical incidents and acts of medical and/or administrative negligence.

COUNT I - MEDICAL NEGLIGENCE OF ACH FOR THE FIRST SURGERY

71. ACH, by and through its managers, department heads, administrators, agents, employees, and surgery team, acting on behalf of ACH, without Plaintiffs’ consent, operated on the left hemisphere (side) of Cody’s brain. Defendants performed a complete brain craniotomy on the wrong (left) side of Cody’s skull and brain, and then closed up the opening in Cody’s skull and scalp on this wrong side without informing Cody’s parents.

72. Specifically, ACH, by and through its managers, department heads, administrators, agents, employees, and surgery team acting on behalf of ACH violated the standard of care in the following particulars:

a) By failing to exercise the care and precautions required in the circumstances to prevent injury to a minor child;

- b) By lacking the required knowledge and skills; and, by failing to consult in order to acquire the knowledge necessary to avoid injury to a minor child;
- c) By failing adequately to evaluate Cody's epilepsy and by failing to consider and/or ignoring alternatives for treating Cody's epilepsy other than by surgery;
- d) By failing to supply sufficient information to enable Plaintiffs to make a reasonable and intelligent decision to give or withhold consent to a left-brain surgery;
- e) By failing to adequately inform Plaintiffs of the attendant dangers involved in the procedures performed;
- f) By failing to obtain Plaintiffs' consent to brain surgery on the left (hemisphere) side;
- g) By failing to use ordinary care for the safety of Cody by performing surgery on the wrong (hemisphere) side of Cody's brain.
- h) By failing to use ordinary care for the safety of Cody by performing a non-consensual second surgery on the right brain after first performing surgery on the wrong side (left) brain.
- i) By failing to hold sufficient pre-epilepsy surgery meetings to identify the correct area to be operated upon and to establish a protocol to prevent a wrongful surgery;
- j) By failing to prepare the right hemisphere for surgery and by failing to discover while preparing the wrong hemisphere for surgery;
- k) By failing to properly mark Cody's head on the right (correct) side prior to surgery;
- l) By failing to adequately check the MRI or EEG or the previous medical

records prior to surgery to confirm the correct area of Cody's brain for surgery;

m) By failing to adequately follow the JCAHO required Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery;

n) By performing surgery on the wrong (left) hemisphere/side of the brain;

o) By wrongfully removing critical brain tissue from the wrong (left) hemisphere/side of the brain;

p) By failing to realize or know they were performing surgery on the wrong (left) hemisphere/side of Cody's head;

q) By breaching the standard of care to stop and take appropriate measures once they did know they were performing surgery on the wrong (left) hemisphere/side of his brain;

r) By breaching the standard of care by completely performing a brain craniotomy on the wrong (left) hemisphere/side of Cody's brain;

s) By generally acting with negligence, imprudence, and lack of expertise under the circumstances.

73. The above-described acts and/or omissions were the proximate cause of damages and injury to Plaintiffs.

74. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH in conducting the first invasive surgical procedure on Cody's brain without consent of his parents committed outrageous and wrongful actions and omissions and breached its duties of care owed to Cody as a patient. ACH directly and proximately caused him serious permanent injury and weakening of his skull, scaring and

disfigurement, damage to his executive function skills, damage to his emotional capacity, past and future pain, suffering and mental anguish, humiliation, embarrassment, past, present and future medical expenses, expenses for corrective surgery, and loss of prospective earning and earning capacity in an amount to be proven at trial. ACH has by its negligent acts and omissions aggravated pre-existing injuries enumerated above

COUNT II - MEDICAL NEGLIGENCE OF ACH FOR THE SECOND SURGERY

75. Immediately following the first surgery with Cody, ACH, by and through its managers, department heads, administrators, agents, employees, and surgery team acting on behalf of ACH, without Plaintiffs' consent, performed a second surgery on the right side of Cody's brain. ACH completely performed a second brain surgery on the right side of Cody's skull and brain, and then closed up the opening in Cody's skull and scalp on the right side. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH did so without obtaining the necessary consent and without informing Plaintiffs of the risks involved with a second brain surgery.

76. Specifically, ACH, by and through its managers, department heads, administrators, agents, employees, and surgical team acting on behalf of ACH, violated the standard of care in the following particulars:

- a) By failing to exercise the care and precautions required in the circumstances to prevent injury to a minor child;
- b) By lacking the required knowledge and skills; and, by failing to consult in order to acquire the knowledge necessary to avoid injury to a minor child;
- c) By failing to supply adequate information to enable Plaintiffs to make a

reasonable and intelligent decision to give or withhold consent to a second surgery on the right side of Cody's brain after performing an invasive and wrongful surgery to the left side of Cody's brain;

d) By generally acting with negligence, imprudence, and lack of expertise under the circumstances.

77. The above-described acts and/or omissions were the proximate cause of damages and injury to Plaintiffs.

78. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH in conducting the first invasive surgical procedure on Cody's brain without consent of his parents committed outrageous and wrongful actions and omissions and breached its duties of care owed to Cody as a patient. ACH directly and proximately caused him serious permanent injury and weakening of his skull, scarring and disfigurement, damage to his executive function skills, damage to his emotional capacity, past and future pain, suffering and mental anguish, humiliation, embarrassment, past, present and future medical expenses, expenses for corrective surgery, and loss of prospective earning and earning capacity in an amount to be proven at trial. ACH has by its negligent acts and omissions aggravated pre-existing injuries enumerated above.

THIRD CAUSE OF ACTION OUTRAGE AGAINST ACH

79. The facts and allegations recited in paragraphs 1 through 78 are incorporated by reference and made a part hereof as though set out verbatim.

80. After breaching standards of care constituting administrative and medical

negligence, ACH, by and through its managers, department heads, administrators, agents, employees, surgery team, and managing board acting on behalf of ACH, under circumstances where they knew or should have known that extreme damages had occurred, with reckless disregard for the truth and with conscience indifference, covered and concealed the consequences of removing brain tissue from both sides of Cody's brain. The conduct, which occurred after the administrative and medical negligence and under circumstances as pleaded herein, constitutes a separate, distinct, and independent tort.

81. After the acts of administrative and medical negligence pled above, ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH failed to properly preserve the evidence, failed to dictate, record and otherwise prepare accurate, complete, and objective medical records of the incidents including but not limited to operative notes of the surgical procedures that were actually performed. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, intentionally and falsely misrepresented and concealed by record, deed, omission and action the true facts about their malpractice conduct.

82. Therefore, Defendants engaged in a cover-up that would and should shock the conscience of this community and is beyond the realm of human decency.

83. The false statements and cover-up consisted of words, communications, and conduct that obscured the fact that the wrong side of the brain was operated upon and that serious and permanent consequences of double-sided brain surgery existed.

84. Pursuant to Arkansas law, a wrongful surgery must be disclosed to a patient and the patient's guardians and next friends. Medical records including but not limited to the

Intraoperative Report and post surgery records or chart notes of ACH fail to indicate that a complete surgery was performed on the wrong side of Cody's brain. Further, neither the Operative Report nor Discharge Summary of ACH indicates that a complete surgery was performed on the wrong side of Cody's brain.

85. At no point during this first surgery, or after the first surgery did ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, communicate with Pamela and Kenny Metheny regarding the surgery having been performed on the wrong side of Cody's brain. During the two surgeries, which lasted approximately ten (10) hours, members of the surgical team gave Cody's parents report during the surgeries that "everything was fine" when in fact everything was not "fine."

86. After the surgeries, ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, told Plaintiffs and the press that everything was fine except that Cody's surgery merely had been "started on the wrong side." ACH further represented in the medical records and to the parents that, "no harm to the brain was done on the left side."

87. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, and its public relations department, knowingly published to the public-at-large, and to the Plaintiffs, specifically false, misleading, and dishonest facts about the surgeries. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH affirmatively represented to the parents, the press, and the public that they only made an incision in the skin of the skull, discovered their mistake, and closed the incision.

88. Moreover, after publication in the press, ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, acquiesced, allowed, endorsed, ratified and adopted this false publication in the press about this surgery for the benefit of maintaining a cover-up. Thus, ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, ratified, embraced, approved, endorsed, and/or accepted the false statements to benefit themselves and profit from the press coverage to garner more surgeries and more income for ACH.

89. While Plaintiffs and the press were told that only an incision had been made on the wrong side of Cody's head, in reality, (a) a complete surgical procedure, including removal of critical brain tissue had been performed on that wrong side, and (b) a second surgery on the opposite side had been performed by the ACH surgical team.

90. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, knew or should have known that the representations to Plaintiffs were inaccurate, false and/or misleading.

91. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, further knew or should have known that their conduct was extreme, outrageous, beyond all possible bounds of decency, and utterly intolerable in a civilized community.

92. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, induced Pamela and Kenny Metheny to:

a) Rely upon the representations made to them that brain surgery was performed on the correct side of the brain and that no harm was done to Cody, so that Cody

would continue to be a patient of ACH and/or UAMS,

b) Refrain from investigating and reporting the wrongful acts and omissions of ACH, and

c) fail to seek proper and necessary medical attention and rehabilitation for Cody which prevented him from having the proper continuity of medical treatment.

93. Plaintiffs did so justifiably rely on ACH's false representations.

94. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, knew or should have known in light of the surrounding circumstances that emotional distress was likely to result due to their conduct; and that Plaintiffs would not become aware of the two complete surgeries. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, knew or should have known in light of the surrounding circumstances that without the chance of aggressive brain treatment and rehabilitation, more irreparable harm would occur to Cody's brain and Cody would be deprived of the proper continuity of medical care.

95. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH's actions, misrepresentations, and concealment evidenced a willful and wanton disregard of Cody's health and safety, for which Plaintiffs seek damages. The actions of ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, were the cause of Plaintiffs' distress; and emotional distress coupled with physical injuries were sustained by Plaintiffs, and the emotional distress was and continues to be so severe that no reasonable person could be expected to endure it.

96. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH's willful and wanton actions toward Cody and Pamela and Kenny Metheny directly and proximately heightened and caused severe emotional distress and anxiety to Plaintiffs. Pamela and Kenny Metheny's anxiety, stress, trouble sleeping, nightmares, night sweats, among other things, have been a direct and proximate result of these willful and wanton actions and omissions.

97. In addition to the outrageous conduct of ACH, by and through its managers, department heads, administrators, agents, employees and/or any other personnel acting on behalf of ACH towards the Plaintiffs, the wrong side surgery was also not reported to hospital reporting and accreditation organizations such as JCAHO or the Arkansas State Medical Board. By failing to report the wrong side surgery to applicable accreditation entities such as JCAHO and/or the Arkansas State Medical Board; ACH, as part of the overall cover up scheme, failed to treat the wrong side surgery as a sentinel event and to take follow-up action to determine what medical treatment was necessary for Cody.

98. ACH, by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, willfully, wantonly, fraudulently, dishonestly, recklessly, maliciously, by commission and omission committed acts that were utterly intolerable, and which would shock the conscience of this community. ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf of ACH, knowingly failed to inform or communicate with Plaintiffs regarding the surgery performed on the wrong side of Cody's brain. Further, ACH by and through its managers, department heads, administrators, agents, employees and surgery team acting on behalf

of ACH, should not be entitled to any immunity status because they engaged in willful, wanton, intentional, fraudulent, dishonest, reckless, and malicious acts.

99. Under Ark. Code Ann. § 16-120-103, covering charitable immunity, the acts or omission of directors of nonprofit corporations or members of boards, commissions, agencies, authorities, or other governing bodies of any governmental entity which constitute intentional torts committed by a director or member are not extended the courtesy of immunity.

100. Further, Arkansas law does not grant immunity for intentional and fraudulent acts to the State of Arkansas, to the counties, to volunteer doctors and healthcare organizations, to athletic officials, to the schools and their boards, to the University of Arkansas for Medical Sciences, of which ACH is an affiliate, and neither should said immunity be granted in this case for ACH. Defendant is jointly and severally liable for damages flowing from this conduct.

**FOURTH CAUSE OF ACTION
OUTRAGE AGAINST THE MEDICAL ASSURANCE COMPANY**

101. The facts and allegations recited in paragraphs 1 through 99 are incorporated by reference and made a part hereof as though set out verbatim.

102. After conducting the wrong side brain surgery, the second unauthorized brain surgery, and the double-sided brain surgery, ACH informed Med. Assurance of the events.

103. Med. Assurance knew or should have known in light of the surrounding circumstances a wrong side brain surgery, a second unauthorized brain surgery and a double sided brain surgery had been inflicted upon Cody Metheny.

104. Med. Assurance knew or should have known in light of the surrounding circumstances that neither Cody Metheny, his parents, JHACO nor the Arkansas State Medical

Board were aware of the wrong side brain surgery, the second unauthorized brain surgery, or the double sided brain surgery.

105. Further, upon information and belief, Med. Assurance, by and through its agents and representatives, advised ACH to not report this as a sentinel event even though they knew or should have known it was a sentinel event in furtherance of a cover-up. By advising the hospital in this manner defendant acted in concert with ACH to commit outrageous acts and omissions which would shock the conscience of the community, including influencing and/or directing the manner in which medical decisions were made for Cody Metheny in order to avoid or limit an insurance claim and/or in anticipation of litigation. Further, Defendant Med. Assurance knew or should have known that they were affecting the medical care and treatment of Cody Metheny to his detriment and to their benefit for purposes of defending a lawsuit.

106. Med. Assurance knew or should have known in light of the surrounding circumstances that ACH and its medical personnel did not document the wrong side brain surgery, the second unauthorized brain surgery, or the double sided brain surgery and encouraged as well as advised through its agents that the incident should not be reported as a sentinel event to JHACO which aided and abetted the cover-up.

107. Med. Assurance knew or should have known in light of the surrounding circumstances that ACH and its medical personnel were required to disclose the wrong side brain surgery, the second unauthorized brain surgery, and the double sided brain surgery to Cody Metheny and his parents, to document accurate, complete and objective notes of the surgical procedures actually performed, and to report the surgical procedures to hospital reporting and accreditation organizations JHACO and the Arkansas Medical Board.

108. Med. Assurance knew or should have known in light of the surrounding circumstances that if procedures actually performed were not disclosed, documented, and reported as described: (1) Cody Metheny and his parents would naturally and probably not discover about the surgical procedures actually performed; (2) JHACO and the Arkansas State Medical Board would naturally and probably never know of the surgical procedures actually performed and refrain from investigating, reporting, and/or sanctioning ACH; (3) Cody Metheny and his parents would naturally and probably fail to seek proper and necessary medical attention and rehabilitation for Cody; (4) Cody Metheny naturally and probably would suffer more irreparable harm without such medical attention and rehabilitation; and (5) Cody and his parents would naturally and probably suffer severe emotional distress.

109. Having known or having reason to have know in light of the surrounding circumstances that failing to disclose, document and report the surgical procedures actually performed would naturally and probably result in irreparable harm to Cody and severe emotional distress to Cody and his parents, and for the purpose of limiting exposure to an insurance claim and/or lawsuit, Med. Assurance acted in concert with and/or directed ACH by and through its managers, department heads, administrators, risk mangers, agents, employees, and surgery team acting on behalf of ACH to prevent disclosure, to limit complete and accurate documentation, and to falsely report the surgical procedures performed on Cody. Med. Assurance's acts and omissions served to cover up the medical and administrative negligence of ACH in reckless disregard of the consequences and which directly and/or indirectly and adversely affected medical decisions being made regarding Cody's care and treatment.

110. Med. Assurance willfully and wantonly engaged in the cover-up by conducting actions and omissions so outrageous in character and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society.

111. The cover up proximately caused damage to Cody Metheny and his parents in the nature of severe emotional distress to Cody Metheny and his parents and irreparable brain injury to Cody Metheny.

112. As a proximate result of the cover-up, the emotional distress suffered by Cody Metheny and his parents was reasonable and justified under the circumstances and was so severe that no reasonable person could be expected to endure it.

VI. CAUSATION

113. The facts and allegations recited in paragraphs 1 through 110 are incorporated by reference and made a part hereof as though set out verbatim.

114. As a direct and proximate result of the unlawful acts and omissions of Defendants, Plaintiffs have suffered damages, as more particularly described above. In addition, punitive damages should be granted.

VII. DAMAGES

115. The facts and allegations recited in paragraphs 1 through 112 are incorporated by reference and made a part hereof as though set out verbatim.

116. After these surgeries, Cody has experienced permanent, serious injuries and aggravation of existing injuries including *inter alia* brain damage, gross disfiguration and weakening of his skull, increased seizure episodes, fear and anxiety, humiliation, behavioral

changes, emotional changes, short term memory and word finding deficits, attention deficit, sleep problems, hallucinations, damage to his executive function skills, mental anguish, loss of enjoyment of life, fear of the unknown, pain and suffering, decreased opportunity for life-time earning and earning capacity, and his present and future medication and attendant medical expenses have changed and will continue to increase in the future to such an extent that his damages are irreparable, irreversible, and permanent.

117. After these surgeries, Cody has a higher probability of suffering from and will now more likely than not develop degenerative and debilitating syndromes, including, but not limited to early onset of Alzheimer's disease, dementia, and schizophrenia.

118. All of the actions and omissions described in this Complaint were committed under circumstances where ACH and Med. Assurance knew or should have known in light of the surrounding circumstances that emotional distress was a likely result of their conduct.

119. Plaintiffs experienced severe stress and anxiety because of the wrongful surgery on the brain and as a result of the actions and omissions of ACH, by and through its managers, department heads, administrators, risk managers, agents, employees and surgery team acting on behalf of ACH. Because two complete invasive surgeries were performed on Cody's brain, which caused him permanent, serious injury and brain damage, as well as gross disfiguration and weakening of his skull, Cody and his parents Pamela and Kenny Metheny have suffered and continue to suffer damage and injury including but not limited to extreme stress, anxiety, emotional trauma, worry, depression, sleeplessness, nightmares, and weakness. The emotional distress sustained by Plaintiffs was so severe that no reasonable person could be expected to endure it.

VIII. THE CIVIL JUSTICE REFORM ACT OF 2003 IS UNCONSTITUTIONAL

120. Pursuant to the United States Constitution and the Arkansas State Constitution, Plaintiffs specifically object and reserve the right to contest the constitutionality and applicability of Act 649 of 2003. In the 2003 Session of the Arkansas General Assembly, the legislature passed an Act entitled The Civil Justice Reform Act of 2003 ("the Act"), which was signed by the Governor and became effective on or about March 27, 2003, and is codified presently at Ark. Code Ann. § 16-55-201, et seq. This is an action in tort and medical negligence accruing after the effective date of the Act.

121. The Act violates Article 5, § 32 of the Arkansas State Constitution, which plainly prohibits legislative limitations on recoveries and Article 4, §§ 1-2 of the Constitution, which prohibit legislative incursions on judicial power. Additionally, the Act violates the constitutional scheme that formally worked to limit governmental incursion on common law rights and limited legislative power to assist special interests. This scheme is embodied in the provisions in Article 2, §§ 4, 13, and 21, recognizing the right to petition the government for redress; Article 2, § 13, guaranteeing the right of every injured person to a remedy; Article 2, § 7 prescribing a right to a jury trial which "shall remain inviolate;" Article 2, §§ 13 and 21, mandating due process and application of the law of the land; Article 2, §§ 3, 18, and 21, recognizing that all citizens shall receive equal treatment and the related Article 5, § 25, limiting unequal treatment to times when it is justified; requiring "that where a general law can be made applicable, no special law shall be enacted."

122. The Act provides various onerous, burdensome, and unconstitutional provisions, which include, but are not limited to, the requirement of specialty affidavits prior to instituting

suit, limitations on the amount of punitive damages, provisions creating “phantom defendants,” the abrogation of traditional rights to plea joint and several liability, to name a few. It is the position of the Plaintiffs that the Act is unconstitutional under the United States Constitution and the Arkansas State Constitution, and the fact that Plaintiffs have attempted to comply with some of the provisions in order to not delay the proceedings herein are not to be construed as a waiver thereof.

123. In the event that it is alleged that Plaintiffs have not complied with any provision of the Act, or that Plaintiffs are bound by any of its onerous and unconstitutional constraints or provisions, Plaintiffs pray for a declaratory judgment that the Act is in and of itself unconstitutional, in whole or in applicable parts.

124. Plaintiffs hereby give notice of the challenge to the constitutionality of the Act to the Arkansas Attorney General, Honorable Dustin McDaniel.

IX. DEMAND

125. The facts and allegations recited in paragraphs 1 through 122 are incorporated by reference and made a part hereof as though set out verbatim.

126. Plaintiffs hereby demand a trial by jury.

127. Plaintiffs reserve the right to amend their Complaint to add additional parties and/or causes of action.

128. Plaintiffs are entitled to punitive damages for any actions and omissions of the Defendants, which are outrageous, made knowingly, or with such reckless indifference to Plaintiffs that malice can be inferred.

129. Plaintiffs reserve the right to file amended and additional pleadings after further

investigation and discovery.

WHEREFORE, Plaintiffs pray for all relief requested herein from Defendants jointly and severally, including compensatory and special damages, punitive damages, and loss of prospective earnings to be proven at trial, costs, attorney's fees as allowed by Arkansas law, and for all other relief deemed just and appropriate.

Respectfully submitted,

Pamela and Kenny Metheny,
As Co-Conservators for Cody Metheny and
Individually as PLAINTIFFS

BY:



Phillip J. Duncan, #74039
James H. Bartolomei, #2005181
DUNCAN FIRM, P.A.
900 South Shackleford, Suite 725
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501-228-7600
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AND

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DAVIS BETHUNE & JONES
1100 Main St., Ste. 2930
PO Box 26250
Kansas City, MO 64196
816-421-1600

Dated: March 6, 2009

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I, Phillip Duncan, the undersigned counsel, hereby certify that a true and correct copy of

23rd / JHB

the foregoing was served upon the following counsel of record on this, 6th day of March 2009:

William Griffin, Esq.
Mr. Jason B. Hendren, Esq.
FRIDAY, ELDREDGE & CLARK, LLP
2000 Regions Center
Little Rock, Arkansas 72201

Attorneys for The Medical Assurance Company, Inc.


Phillip Duncan

SEP 20 2011

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

PAMELA AND
KENNY METHENY,
Individually and as Co- Conservators
for Cody Ryan Metheny

CLAIMANTS

v.

NO. 12-0196-CC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

RESPONDENT

ANSWER

Comes now the respondent, University of Arkansas for Medical Sciences (UAMS) by and through its undersigned counsel, and for its Answer to the Complaint of claimants, Pamela and Kenny Metheny, states as follows:

1. Respondent admits the allegations contained in Paragraph 1 of the Verified Complaint.
2. Respondent admits the allegations contained in Paragraphs 2 and 3 of the Verified Complaint.
3. Respondent admits the allegations contained in Paragraph 4 of the Verified Complaint, with the exception that Respondent does not currently have sufficient information or knowledge to admit or deny whether Cody Ryan Metheny presently resides part-time in a neuro-rehabilitation facility in Virginia, and therefore denies that allegation at this time.
4. Respondent admits that UAMS is a campus of the University of Arkansas, and that UAMS and Arkansas Children's Hospital (ACH) have agreements whereby UAMS physicians practice at ACH. Respondent denies each and every other allegation contained in Paragraph 5 of the Verified Complaint. Respondent specifically denies that it was involved in the care of Cody Ryan Metheny; that UAMS and ACH have an "alter-ego relationship" for pediatric patient care;"

or that UAMS “represents, relates and holds ACH out to the public as its pediatric affiliate in the State of Arkansas.”

5. Respondent denies each and every allegation contained Paragraph 6 of the Verified Complaint. Respondent affirmatively states that its pediatric physicians practice medicine at ACH, and have privileges at that hospital. However, other patient care professionals, such as nurses and technicians at ACH are ACH employees, not those of UAMS. ACH is not an “alter ego” of UAMS.

6. Respondent denies each and every allegation contained in Paragraph 7 of the Verified Complaint. Respondent specifically denies that UAMS, through its “alter-ego” ACH, operated on Cody Ryan Metheny. Respondent further affirmatively states that the medical record speaks for itself regarding surgery that was performed on Cody Ryan Metheny at ACH.

7 Respondent denies each and every allegation contained in Paragraph 8 of the Verified Complaint. Respondent specifically denies that ACH is an “alter-ego” of UAMS; that UAMS failed to provide any information to the claimants; and that any medical errors that might have been performed by ACH are inputed to UAMS, “its parent administrative governmental entity pursuant to their formal affiliation.” Respondent is without sufficient information or knowledge to admit or deny the particulars of the Pulaski County, Arkansas case or its status on appeal, and thus will not state any position regarding those allegations. Respondent does admit and agree that this matter should be stayed until all recourse against private insurance is exhausted through the judiciary process. Respondent also understands that if claimants recover an adequate amount of insurance proceeds in the court case, they will not pursue this claim before the Commission.

8. Respondent denies each and every allegation contained in Paragraph 9 of the Verified Complaint, with the following exception: respondent agrees that claimants have attached

to their Verified Complaint as Exhibit 2 a copy of their First Amended Complaint, filed March 6, 2009 in the Circuit Court of Pulaski County, Arkansas, Case No. CV 09-96; that UAMS has made no payment to the claimants; and that no amount has been ascertained by the Commission, nor has any decision been made whatsoever by the Commission regarding this claim.

9. Respondent agrees that this claim should be held in abeyance and stayed pending resolution of the Pulaski County, Arkansas Circuit Court case that is currently on appeal.

10. Respondent denies each and every allegation contained in the Verified Complaint that has not been specifically admitted herein.

11. Respondent affirmatively states that all matters alleged in this Verified Complaint which deal with alleged inappropriate treatment of Cody Ryan Metheny by ACH is the responsibility of ACH and not UAMS.


12. Should any amount ultimately be award in this claim, it would be charged against Cost Center Number 1001656.

WHEREFORE, having fully answered claimants' Verified Complaint, respondent prays that said Complaint and this case be held in abeyance pending the ultimate outcome of the pending Pulaski County, Arkansas Circuit Court case that is on appeal, and that ultimately the Complaint and this claim be denied and dismissed in its entirety, and for all other relief to which it may be entitled.

Respectfully submitted,

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES, Respondent

By:



JEFFREY A. BELL, ABA #77009
Sr. Associate General Counsel
University of Arkansas
2404 North University Avenue
Little Rock, AR 72207-3608
(501) 686-2520

CERTIFICATE OF SERVICE

I, Jeffrey A. Bell, do hereby certify that a copy of the foregoing pleading has been served on claimant herein by mailing a copy of same, by U.S. Mail, postage prepaid, this 16th day of September, 2011 addressed to the following:

Mr. Phillip J. Duncan
Mr. Richard Quintus
Mr. William Rob Pointer
Mr. Justin Zachary
Duncan Firm, P.A.
900 South Shackleford, Suite 725
Little Rock, AR 72211

Mr. Grant L. Davis
Mr. Thomas C. Jones
Davis, Bethune & Jones
P. O. Box 26250
Kansas City, MO 64196


Jeffrey A. Bell

**BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas**

PAMELA and KENNY METHENY,
Individually, and as Co-Conservators
for CODY RYAN METHENY

Claimants,

v.

UNIVERSITY OF ARKANSAS FOR
MEDICAL SCIENCES, UAMS

Respondent

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Claim No. #12-0196-CC

CLAIMANTS' FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimants, by and through their counsel, submit the following findings of fact and conclusions of law. The following findings of fact and conclusions of law are supported by the testimony and evidence previously submitted in this case and which will be submitted or referenced at the final hearing on this matter. Supporting material is referenced after each factual paragraph.

1. Findings of Fact

1. Claimants, Pamela and Kenny Metheny, are the parents of Cody Ryan Metheny (entire record, *passim*).
2. On August 2, 2014, Cody Ryan Metheny was a fifteen year old child (entire record, *passim*).
3. Cody Ryan Metheny was treated for epileptic seizures by Dr. Badih Adada, and other physicians at the University of Arkansas Medical Sciences, Pediatric Division, which is located at Arkansas Children's Hospital ("ACH") (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates).
4. In 2004, Dr. Badih Adada was an employee of the State of Arkansas at the University of Arkansas Medical Sciences when he operated on Cody Metheny (Deposition and

trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett and UAMS neurosurgery and affiliation agreement with ACH, UAMS correspondence with Dr. Badih Adada, Deposition and Trial Testimony of Dr. Gregory Sharp).

5. Dr. Adada was employed as an UAMS physician, professor, teacher and department head (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett and UAMS agreement with ACH, UAMS correspondence with Dr. Badih Adada).

6. Dr. Adada was the Chief of Pediatric Neurosurgery at UAMS's pediatric affiliate and alter-ego, ACH, at the time Cody Ryan Metheny was treated (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett, UAMS agreement with ACH, UAMS and ACH documents, UAMS correspondence with Dr. Badih Adada).

7. Dr. Adada was the Chief of Pediatric Neurosurgery for UAMS at the time of the occurrence at issue in this case (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett, UAMS agreement with ACH, UAMS and ACH documents).

8. When a UAMS resident assists Dr. Adada in surgery, in addition to Dr. Adada's role to treat and take care of his pediatric patient as attending surgeon, it is his role to teach, train and supervise the UAMS resident (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Dr. Ali Raja, Testimony of Arthur Shorr, Trial Testimony of Dr. Gregory Sharp, UAMS agreement with ACH, Medical by-laws, UAMS and ACH documents), including completing the discharge summary.

9. Administratively, UAMS, through its pediatric affiliate and alter-ego ACH, and Chief of Pediatric Neurosurgery, Dr. Adada, and UAMS resident assistant neurosurgeon, Dr. Raja, operated on Cody Ryan Metheny on August 2, 2004, to remove a right-sided lesion. This surgery was performed during a teaching and residency neurosurgery program (Deposition and

trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett, UAMS agreement with ACH, UAMS and ACH documents).

10. UAMS is a division of the University of Arkansas. UAMS and ACH have been affiliated through formal agreement and by relationship since 1982, because ACH did not have a Pediatric Division. UAMS became the pediatric clinical care partner, affiliate and alter-ego of ACH for treating and operating on children in ACH (Deposition and trial testimony of Dr. Johnathon Bates, Vicki Bennett, Deposition of Bonnie Taylor, UAMS agreement with ACH, FTC Advisory Opinion, UAMS Medical Student materials, UAMS organizational charts, UAMS and ACH documents and UAMS correspondence).

11. The formal affiliation between UAMS and ACH is both contractual and administrative and creates a direct patient relationship between UAMS and pediatric patients at ACH who are treated by UAMS physicians and faculty, as employees of the State of Arkansas (Deposition and trial testimony of Dr. Johnathon Bates, Vicki Bennett, Deposition of Bonnie Taylor, UAMS agreement with ACH, FTC Advisory Opinion and UAMS and ACH documents).

12. The medical director at the time of the occurrence at issue in this case was the same for UAMS and ACH, Dr. Bonnie Taylor, M.D (Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Bonnie Taylor, UAMS agreement with ACH, UAMS correspondence with Bonnie Taylor, UAMS Medical Student materials, UAMS organizational charts, UAMS and ACH documents and UAMS correspondence).

13. The medical director is hired through a joint process between UAMS and ACH. The medical director is responsible for the medical staff comprised of UAMS physicians and faculty, hospital clinical policies and patient care, including sentinel events and root cause analysis and completion of the medical record (Deposition and trial testimony of Dr. Johnathon

Bates, Deposition of Dr. Bonnie Taylor, UAMS agreement with ACH, UAMS correspondence with Bonnie Taylor, UAMS Medical Student materials, UAMS organizational charts, UAMS and ACH documents and UAMS correspondence, ACH medical record, ACH medical policies).

14. UAMS pays Dr. Badih Adada's and other UAMS physicians' salaries because the physicians are State of Arkansas employees. Pursuant to agreement and testimony, Dr. Badih Adada was, at all times while taking care of his patients at ACH, an employee of UAMS (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Trial Testimony of Dr. Gregory Sharp, Vicki Bennett and UAMS neurosurgery and affiliation agreement with ACH, UAMS correspondence with Dr. Badih Adada).

15. UAMS doctors provide the pediatric care at its partner, ACH (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett and UAMS neurosurgery and affiliation agreement with ACH, UAMS correspondence with Dr. Badih Adada, Deposition of Dr. James Grady Crosland, Deposition of Dr. Gregory Sharp, Deposition of Dr. Ali Raja, Deposition of Manual Gorrin-Rivas, Deposition of Scott Suhrer).

16. UAMS houses its pediatric neurosurgery division at ACH.

17. ACH is the Arkansas teaching and residency hospital for treatment of children by UAMS.

18. UAMS faculty members/doctors, chiefs of professional services and professional staff administratively function with ACH performing the professional and administrative functions for medical care and judgment at the State's children's hospital.

19. UAMS doctors draft medical policies, provide medical judgment, clinic care, operate on children, supervise, teach and train UAMS residents during pediatric care.

20. UAMS's Department of Pediatrics, ACH, offer a wide range of pediatric medicine programs caring for more than 10,000 inpatient admissions.

21. UAMS represents, relates and holds ACH out to the public as its partner, pediatric affiliate and alter-ego in the State of Arkansas. For example, "UAMS Doctors. Arkansas Children's Hospital. Two Great Partners."

22. UAMS further represents its partnership with ACH on its webpage:

"Through our **partnership** with Arkansas Children's Hospital, our services include pediatric training, clinical assessment, diagnosis and treatment of acute and chronic disorders, and cutting-edge research on techniques to enhance a child's home and medical environment."

23. The United States Federal Government has recognized the close relationship between UAMS and ACH for pediatric care in Arkansas. An official Federal Trade Commission ("FTC") advisory opinion issued on March 13, 2003 (thirteen months before the multiple brain surgeries) affirmed the following facts:

- a. UAMS and ACH established a joint venture to care for children at the outpatient clinics operated on the ACH campus;
- b. UAMS and ACH have a "common purpose" to care for the same pediatric patients;
- c. UAMS and ACH deliver patient care for a common patient population;
- d. UAMS's Department of Pediatrics is located on the ACH campus;
- e. UAMS and ACH coordinate their clinical services, education programs, and research;
- f. "All the clinics are staffed by UAMS physicians, and UAMS personnel have a direct role in the clinical management of ACH....";

- g. UAMS physicians serve as medical directors over ACH departments and over ACH; and
- h. UAMS clinically manages ACH and its patients and is administratively responsible for the welfare and safety of children injured by doctors at ACH.

24. Medical testimony under oath regarding UAMS and ACH, as alter-egos, and the interrelationship between the two entities is as follows:

Pursuant to her testimony, Bonnie Taylor MD, a UAMS professor serves as Medical Director for ACH and Senior Vice-President. All the medical committees at ACH are staffed by UAMS employee physicians. The medical committees are charged with the formation and development of all medical care policies, procedures and procedure at ACH. All medical committees function under the direction of Dr. Taylor in her capacity as Medical Director. All of the physicians were subject to her clinical administrative oversight. The Medical Director for ACH is also required to function as Chairman of UAMS' Department of Pediatrics and as UAMS faculty. As such, the Medical Director for ACH is constructively appointed by the UAMS Chancellor. (Deposition of Dr. Bonnie Taylor, Deposition and trial testimony of Dr. Johnathon Bates, agreement between UAMS and ACH, medical policies and ACH Medical Staff Rules and Regulations).

25. Dr. Badih Adada, as an employee of the State of Arkansas, had a direct patient relationship with Cody Metheny. (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition of Vicki Bennett). On August 2, 2004, the UAMS Chief of Pediatric Neurosurgery, Dr. Badih Adada, while teaching a UAMS resident physician, Ali Raja, opened a large brain flap and entered deep into the wrong side of Cody Metheny's brain. (Deposition and trial testimony of Dr. Badih Adada, Deposition of Dr. Ali Raja, Deposition of Dr. James Grady Crosland, Deposition of Dr. Johnathon Bates, Dr. Stephen Nokes, medical records). Dr. Adada removed a large section of the healthy brain on the incorrect side, which caused extensive and permanent, irreparable harm

and removed brain tissue on both sides of Cody Metheny's brain, including, but not limited to the amygdala and hippocampus areas of the brain. (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Ali Raja, Testimony of Arthur Shorr, Deposition and trial testimony of Dr. Gregory O'Shanick, Deposition and trial testimony of Dr. Peter Patrick, Deposition of Dr. Steven Nokes).

26. After the multiple hour surgery on the wrong side of the brain, the patient was turned over, re-prepped and, even though contra-indicated, surgery took place on the other side of his brain thereby damaging similar areas on both sides of Cody's brain (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Ali Raja, Testimony of Arthur Shorr, Deposition and trial testimony of Dr. Gregory O'Shanick, Deposition and trial testimony of Dr. Peter Patrick, Deposition of Dr. Steven Nokes).

27. Cody had significant brain tissue removed from the amygdala and hippocampus area on both hemispheres of his brain (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Ali Raja, Testimony of Arthur Shorr, Deposition and trial testimony of Dr. Gregory O'Shanick, Deposition and trial testimony of Dr. Peter Patrick, Deposition of Dr. Steven Nokes).

28. During the first, wrong-sided surgery, UAMS physician and state employee, Dr. Adada, and his assistant neurosurgeon, UAMS resident physician Dr. Ali Raja, conferred and privately discussed the wrong-sided surgery when it occurred approximately three and half hours into the surgery when Dr. Adada realized he was on the wrong side and into the left side of Cody's brain. (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr.

Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland).

29. However, neither UAMS physician disclosed the wrong side brain removal to the parents of Cody Metheny. Indeed, to the contrary, Dr. Adada testified that he affirmatively told the parents he did not harm the brain. Neither doctor obtained informed consent from Cody's parents to continue to operate on the correct side of Cody's brain after the erroneous wrong side surgery. (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Deposition testimony of Dr. John Shershow, medical records).

30. Pamela and Kenny Metheny were never provided the opportunity to seek immediate treatment from another healthcare provider or to decline the subsequent surgery after the botched surgery (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).

31. UAMS physician, and head of pediatrics, Dr. Bonnie Taylor, who was the Medical Director for ACH, testified under oath in her deposition that she knew of the wrong-side brain surgery within one day of its occurrence (Deposition of Dr. Bonnie Taylor).

32. However, Dr. Taylor never met with the parents of Cody Metheny. (Deposition of Dr. Bonnie Taylor). Dr. Taylor never looked at Cody Metheny's medical documentation or his chart. *Id.* Dr. Taylor never had any contact with anyone directly involved in the case. *Id.* Dr.

Taylor never disclosed or revealed any information about the wrong-sided surgery nor follow up at any time with Cody's parents. *Id.*

33. UAMS Professor and state employee, Dr. Badih Adada, dictated and deliberately created a false operative note 28 days after the wrong-sided surgery was performed, and he waited 49 days after the surgery to sign the dictated, false operative note (Deposition and trial testimony of Dr. Badih Adada).

34. Dr. Badih Adada admittedly violated hospital policy for medical record completion and timeliness (Deposition and trial testimony of Dr. Badih Adada).

35. The truth and extent of the brain damage was affirmatively concealed from the parents and was never written in any medical records. (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).

36. A state employee and UAMS resident student being trained and supervised during the occurrence, Dr. Ali Raja, affirmatively concealed and did not disclose the wrong side brain removal in his pediatric patient discharge summary (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).

37. The truth and extent of the wrong-sided brain surgery was never accurately nor adequately disclosed in any medical chart, document, note, or any other type of medical record, which prevented rehabilitation until the Metheny's learned of the missing brain from the wrong

side from a MRI taken about fifteen months later provided by Dr. Stephen Nokes, a radiologist at Baptist Health (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).

38. In depositions and the circuit trial taken during the civil suit filed in Pulaski County Circuit Court after the surgeries were performed, Dr. Badih Adada admitted he was a state employee, that he was liable for committing severe malpractice when he negligently removed a large, healthy section from the wrong side of Cody's brain and admitted that he was responsible for his patient. He further admitted that he did not disclose the damage to the wrong side of the brain (Depositions and trial testimony of Dr. Badih Adada).

39. In the depositions taken during the civil suit filed in Pulaski County Circuit Court after the surgeries were performed, Dr. Badih Adada admitted that he electronically dictated an operative report that was patently false. The falseness of the operative note was only revealed by a lawsuit and formal deposition (Deposition of Dr. Badih Adada).

40. Medical testimony under oath is that, with respect to compliance with the Joint Commission in Accreditation of Healthcare Organizations ("JCAHO"), it was a former surveyor and teacher at JCAHO's most egregious case of JCAHO violations, a white-wash of the medical records and medical fraud. (Testimony of Arthur Shorr, Deposition of Dr. John Shershow).

41. It is universally medically accepted that removing brain tissue on both sides of the brain, particularly the amygdala, hippocampus area, should never be done and will in high likelihood cause serious and permanent disability to the affected patient (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).

42. In particular, removal of both sides of the brain, including the amygdala and hippocampus will cause serious and permanent harm to a patient (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).

43. Medical testimony under oath is that the wrong-sided brain surgeries did cause permanent injury, including loss of enjoyment of life, cognitive loss, loss of natural drive, memory problems, emotional problems, psychotic behavior, hallucinations and other psychotropic events and episodes (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).

44. The substantial evidence shows the injuries caused by the wrong-sided surgery have resulted in Cody Metheny having to be cared for in an institutional setting (Deposition and Trial Testimony, *passim*).

45. The institutional setting included extensive neuro-rehabilitation in Virginia Beach (Deposition and Trial Testimony, *passim*).

46. Medical testimony under oath is that Cody Metheny will now need structured living for the rest of his life, and he will never be self-sufficient ((Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).

47. According to medical testimony, the likelihood of early onset dementia, Alzheimer's and these type of brain-related diseases are more probable than not and are the permanent results of this type of wrong-sided surgery (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).

48. Substantial evidence shows there was a complete administrative breakdown and institutional failure by UAMS, and its partner and pediatric affiliate and alter-ego ACH, to provide truthful information about the wrong-sided surgery (Dr. Badih Adada, Dr. Ali Raja, Dr.

James Grady Crosland, Dr. Gregory Sharp, Dr. Scott Suhrer, Dr. Gorrin-Rivas, Dr. Bonnie Taylor, Dr. Johnathon Bates, Vickie Bennett, Mary McDaniel).

49. Although administrator, including Chief of Neurosurgery, Dr. Badih Adada, knew of the wrong-sided surgery at the UAMS Department of Pediatrics, its administrators went home without notifying the family, following up with the family, documenting the record, and assuring the continuity of medical care while Cody Metheny was a patient and in post-surgical care, all of which is unequivocally required by the rules and standard medical treatment (Deposition and trial testimony of Dr. Badih Adada, Deposition of Dr. Ali Raja, Deposition of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Gregory Sharp, Deposition of Dr. Scott Suhrer, Deposition of Dr. Gorrin-Rivas, Deposition of Dr. Bonnie Taylor, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Vickie Bennett, Deposition of Mary McDaniel).

50. UAMS's systemic failure included the violation of the UAMS "time-out" policy, required by JCAHO, which states, each person in the operating room was required to stop, huddle up, and acknowledge individually and as a group that: this is the correct patient; the correct procedure; the correct position for the patient; the correct side, site and/or body part is being operated upon by the UAMS surgeon. According to medical testimony, this should happen in every single case (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. John Shershow, Testimony of Arthur Shorr, medical records).

51. UAMS also violated the "sentinel event" policy, which constitutes a failure to disclose, suppression of a serious medical error and cover up. When a major event of negligence or death occurs at a hospital, it is referred to as a "sentinel event" and is required to be reported to certification authorities, such as JCAHO. Dr. Badih Adada, Dr. Johnathon Bates and Vickie Bennett recognized the wrong-sided surgeries as a sentinel event. However, no sentinel event

was reported to the accreditation authority, JCAHO (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Vicki Bennett, Trial Testimony of Cheryl Ray, Deposition and trial testimony of Dr. Johnathon Bates).

52. Medical testimony under oath explains how UAMS covered up Cody Metheny's wrong sided- surgery and its importance in this community, stating:

The further direction and control exerted by UAMS physicians over the follow-up documentation, including untimely documentation and ill-conceived futile attempt to create a "white-wash" in the medical record, to suggest that there was no indication of a wrong-side, invasive and permanently harmful surgery. The intent was to prevent any objective review of the medical record evidenced by the non-disclosure of accurate facts to the parents, lack of transparency and accuracy, or objective documentation. **This type of cover-up and failure to document and conceal from families is not supposed to occur at any accredited hospital let alone a tertiary care teaching institution. Such behavior undermines the community's investment and trust in UAMS' role in the teaching and training of the next generation of medical and healthcare professionals,** and public trust in the partnership between the UAMS and ACH. Further it calls into question the ability of ACH to provide "quality, patient care" which it purports to provide tertiary medical and patient care equivalent or better than other children's hospitals around the country. (emphasis added) (Arthur Shorr Affidavit).

53. Substantial evidence and medical testimony under oath show Cody Metheny was directly damaged by the UAMS's systemic breakdown and failure to disclose the wrong-sided surgery and its extent because it prevented Cody from rehabbing his brain within one year of his traumatic injury, which according to medical testimony, is the most important time for the type of neurorehabilitation Cody needed (Deposition and trial testimony of Dr. Gregory O' Shannick, Deposition and trial testimony of Dr. Peter Patrick).

54. During the multiple brain surgeries, medical records were created with inaccurate information. The truth behind the multiple surgeries was not revealed or disclosed to Cody's parents, Pam and Kenny Metheny for over one year, and only after a lawsuit was filed, depositions were taken and medical doctors from Baptist Health reviewed the medical

information contained (or lack thereof) in the UAMS/ACH medical records (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Bonnie, Taylor, Deposition and trial testimony of Kenny and Pamela Metheny, Deposition and trial testimony of Dr. John Shershow, Testimony of Arthur Shorr, medical records).

55. The litigation in this case lasted over ten years from the time of Cody's wrong-sided surgery.

56. The case went to a jury trial in Pulaski County, Arkansas and lasted for two weeks. After numerous witnesses, the in-depth review of enormous amounts of medical information, including the medical records, charts, notes, and listening to medical testimony at length. Evidence was presented that damages were in excess of \$20 million. The jury awarded a verdict for \$20 million, which was entered in favor of the Claimants on September 24, 2010 (Jury verdict & *Pro Assurance v. Metheny* appeal).

57. Attorneys for the pediatric affiliate ACH appealed the jury verdict and argued that ACH, as non-profit, only had to pay up to the amount of its insurance. ACH was successful in reducing the jury verdict to the amount of private insurance available, which left a shortfall of over \$8 million for the permanent, disabling damages experienced by Cody Metheny (Jury verdict and *Pro Assurance v. Metheny* appeal).

58. Claimants exhausted their remedies against tortfeasors with private insurance, including the entire private insurance policy of state employee, Dr. Badih Adada, and the capped insurance for UAMS pediatric affiliate and partner in pediatric clinical care, ACH. The private insurance, which is \$8 million less than the jury verdict awarded Cody Metheny for his damages, is far inadequate to address the permanent, disabling damages experienced by Cody Metheny for

the wrong, botched brain surgeries on August 2, 2004, resulting medical cover-up and failure to disclose to the Metheny family.

2. Conclusions of Law

59. Negligence is defined to mean the failure to do something, which a reasonably careful person would do, or the doing of something which a reasonably careful person would not do, under circumstances similar to those shown by the evidence in this case. *See Wallace v. Broyles*, 331 Ark. 58, 66, 961 S.W.2d 712, 715 (1998). *See* ARK. MODEL JURY INST. (AMI) – Civil 301 (2015 ed)

60. To constitute negligence, an act must be one from which a reasonably careful person would foresee such an appreciable risk of harm to others as to cause him not to do the act, or to do it in a more careful manner. *Id.* The Arkansas Supreme Court has held that to constitute actionable negligence, it is not necessary that the actor foresee the particular injury which occurred, only that the actor reasonably foresee an appreciable risk of harm to others. *Id.* (citing *Jordan v. Adams*, 259 Ark. 407, 533 S.W.2d 210 (1976)) (emphasis supplied).

61. A physician and medical care provider in Arkansas has a duty of care owed to a patient regarding medical treatment, diagnosis, surgery or operation and obtaining informed consent to perform a medical procedure, including disclosing all risks to the patient or the patient's representative.

62. The physician and medical care provider must possess and apply with reasonable care the degree of skill and learning ordinarily possessed and used by members of the provider's profession where the practice is located. A breach and failure of this standard is negligence. *See* AMI 1501.

63. Arkansas law is clear that if the physician or medical care provider (such as Dr. Adada) is an employee of the defendant employer (UAMS), then the defendant employer is vicariously liable under the doctrine of *respondeat superior* for the negligence of the medical care provider. *Chicago, R.I. and P.R. Co. v. Britt*, 189 Ark. 571, 74 S.W.2d 398 (1934) (finding railroad with contract with Little Rock was responsible as employer of surgeon who committed malpractice). Here UAMS physician Dr. Adada admittedly committed severe malpractice. Dr. Adada and other UAMS physicians and State of Arkansas employees altered medical record or provided incomplete and untrue information and failed to disclose material facts. Under the doctrine of *respondeat superior*, these state employees' negligence and tortious behavior binds UAMS. Consequently, under Arkansas law, UAMS is liable for the admitted negligence by UAMS doctors. *Id.*

64. Under Arkansas law, neither Dr. Badih Adada nor any of the other physicians in this case was employed by Arkansas Children's Hospital. Rather, Dr. Adada and the other physicians were employed by the University of Arkansas Medical Sciences at the time of the occurrence at issue in this case.

65. Furthermore, UAMS owed a general duty of care to its common patient population, including Cody Metheny. UAMS knows its doctors, residents and fellows will be operating on pediatric patients and involved in education and training in their specialty at ACH. *See County of Riverside v. Loma Linda University*, 118 Cal.App.3d 300, 173 Cal.Rptr. 371 (1981) ("[T]he university owed a duty to patients who were under the care and treatment of residents to see that the residents received proper education and training in their specialty and proper supervision over the clinical aspect of their training.").

66. Here, UAMS through its partner, affiliate, alter-ego and agent, ACH, breached a general duty of care owed to Cody Metheny for several reasons:

- (1) First, UAMS and ACH's relationship was intended to affect their joint patients;
- (2) Second, UAMS physicians, residents and fellows were known to engage in patient care at its UAMS Pediatric Department located on its ACH campus, thus, harm was foreseeable;
- (3) Third, there is absolute certainty that Cody Metheny was permanently and severely harmed by UAMS conduct occurring at UAMS Department of Pediatrics and admitted liability by UAMS employee Dr. Badih Adada;
- (4) Fourth, there is a closeness of the relationship between UAMS systemic breakdown, involving the "time-out" policy and care and treatment of Cody Metheny at UAMS Pediatric Department;
- (5) Fifth, there was a failure to train and instruct the time-out policy so UAMS employees called and followed a proper timeout procedure at UAMS Pediatric Department;
- (6) Sixth, the UAMS employees failed to properly document the wrong-sided surgeries; and
- (7) A determination that UAMS breached its duty of care in its Pediatric Department will serve to improve patient care and benefit the medical school, hospital, professors, interns and residents.¹

67. UAMS owed a professional duty of care toward Cody, who was a joint and common UAMS/ACH patient, at all relevant times. Moreover, under Arkansas law, UAMS owed a fiduciary duty toward Cody Metheny and his parents, including a duty of full and fair disclosure of all material facts about Cody's surgery and medical condition.

68. A fiduciary duty is the highest duty owed at law. BLACK'S LAW DICTIONARY, at 625 (6th ed. 1990). Medical providers universally and in Arkansas have a "special, confidential relationship" with a patient under well-established law, and, are, therefore, fiduciaries to the

¹ *Id.*

patient. See, e.g., *Howard v. Northwest Ark. Surgical Clinic, P.A.*, 324 Ark. 375, 921 S.W.2d 596 (1996) (finding fiduciary duty for doctor and clinic where doctor worked); *Roberts v. Francis, M.D.*, 128 F.3d 647, 649 (1997) (citing *Howard* and other Arkansas cases). By virtue of Cody's treatment by UAMS Department of Pediatric physicians, there is a special, confidential relationship requiring an utmost degree and duty of care, duty of honesty, good faith, loyalty and duty of full disclosure. See *id.*; see also BRILL, LAW OF DAMAGES § *Fiduciary relationships* at 258; *Deitsch v. Tillery*, 309 Ark. 401, 833 S.W.2d 760 (1992) (failure to disclose is a breach of duty and considered outrageous when involving children).

69. In *Roberts*, the Eighth Circuit cited to Arkansas cases and law holding there was a special, confidential relationship with a patient where a surgical error occurred (ovary removed), which the patient did not know and would not know, but for the disclosure of this factual information by medical providers at the time of the medical error. *Id.* at 649. Full disclosure of the factual information and medical error to the patient was required of the medical provider (i.e., an affirmative duty to speak). The *Roberts* Court stated:

In this case, we find that Dr. Francis' fraudulent concealment of his alleged medical malpractice tolls the statute of limitations. It is undisputed that Dr. Francis removed appellant's only remaining ovary and failed to disclose this information to her. See *Howard v. Northwest Ark. Surgical Clinic, P.A.*, 324 Ark. 375, 921 S.W.2d 596, 599 (1996) (a physician's knowledge of the alleged wrong is a necessary prerequisite to tolling the statute) (citations omitted). In *Union National Bank of Little Rock v. Farmers Bank, Hamburg Arkansas*, 786 F.2d 881 (8th Cir.1986), we stated: "**Under Arkansas law, a party may have an obligation to speak rather than remain silent, when a failure to speak is the equivalent of fraudulent concealment.**" *Id.* at 887 (citing *Berkeley Pump Co. v. Reed-Joseph Land Co.*, 279 Ark. 384, 653 S.W.2d 128 (1983)). With respect to when a duty to speak arises, the Arkansas Supreme Court has stated, "[t]he duty of disclosure ... arises where one person is in [a] position to have and to exercise influence over another who reposes confidence in him whether a fiduciary relationship in the strict sense of the term exists between them or not." *Hanson Motor Co. v. Young*, 223 Ark. 191, 265 S.W.2d 501, 504 (1954) (citation omitted) (emphasis added).

Id. at 649.

70. In this case, the UAMS Chief of Pediatric Neurosurgery, the Medical Director of UAMS, a UAMS employee and resident, and other UAMS administration all knew of Cody's wrong-sided surgery and fraudulently concealed the facts of the surgery when each respective knowledgeable party unilaterally chose to remain silent.

71. Arkansas law has a strong public policy against the concealment, omission and suppression of material evidence with regard to medical care and the treatment of a human, which infers negligence or wrongful conduct. *See, e.g., Smith v United States*, 128 F.Supp.2d 1227, 1233-34 (E.D. Ark. 2000) (finding that physician had failed to dictate a post-surgical note when required by standard medical procedure and public policy); *Carr v. St. Paul Fire & Marine Ins. Co.*, 384 F.Supp. 821, 830 (W.D. Ark. 1974) (recognizing that jury could infer negligence over record that was not retained).

72. Moreover, under Arkansas law, a person commits the offense of tampering with physical evidence if he or she alters, destroys, suppresses, removes or conceals any record, document, or thing with the purpose of impairing its verity, legibility, or availability in any official proceeding or investigation. Ark. Code Ann. § 5-53-111.

73. UAMS, and its physicians, had an affirmative duty of patient care and fiduciary duty to fully disclose all factual information to Cody Metheny's parents, as Cody's guardians and co-conservators. UAMS failed to do so.

74. The Claimants, as the result of direct negligence of UAMS, and a failure to disclose and reveal material medical information, experienced a serious and permanent loss and life-changing event to their son Cody Metheny, resulting in damages award of \$20,000,000, by a Pulaski County jury.

75. The Arkansas State Claims Commission finds UAMS is negligent and responsible for the harm sustained by the Claimants. It is recommended by the Arkansas State Claims Commission that the deficiency in the amount of harm and damages suffered by the Metheny family should be and is hereby compensated by the State of Arkansas in the amount of \$8,000,000, the amount of the Pulaski County jury award not covered by private insurance.

WHEREFORE, Claimants hereby submit their Findings of Fact and Conclusions of Law.

Respectfully submitted,

By:

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Claimants' Counsel

**KANSAS STATE CLAIMS COMMISSION
NON VEHICLE PROPERTY DAMAGE/PERSONAL INJURY INCIDENT REPORT FORM**

SECTION I

CLAIMANT KENNY & PAMELA METHENY **ADDRESS** 7500 40th Street
Little Rock **CITY & STATE** Arkansas **ZIP CODE** 72204

DATE OF INCIDENT: 08/02/2004 **TIME** 10:00 am

Give a brief description of incident, showing how incident happened, exact loss and extent of damage to property and/or injury to person:

Medical Malpractice at Arkansas Children's Hospital, see attached Complaint

(If personal injury claim only, move on to Section IV)

SECTION II

Has this property been repaired? Yes () No () If repairs have been made, give the following information: Amount: \$ _____ Have you paid for the repairs? Yes () No ()

NOTE: Attach a copy of repair bill.

If repairs have not been made, list three estimates below and attach copies of each of them.

NAME	ADDRESS	AMOUNT
1. _____	_____	\$ _____
2. _____	_____	\$ _____
3. _____	_____	\$ _____

SECTION III

Was property covered by insurance? Yes () No ()
 If yes, what is the deductible? \$ _____

NAME OF INSURANCE CARRIER _____ **ADDRESS** _____

SECTION IV

Is injured covered by medical insurance? Yes (Y) No ()

If yes, what is the deductible? \$ unknown

NAME OF INSURANCE CARRIER _____ **ADDRESS** _____

Blue Cross/Blue Shield Alabama

ARKANSAS STATE
CLAIMS COMMISSION

SEP 02 2011

RECEIVED

SECTION V

If incident was investigated by the police or by some other agency, give name and title of officer/person making the investigation: NO

SECTION VI

The undersigned states on oath that he/she is familiar with the matters and things set forth in the above statement, and that he/she verily believes that they are true.



Pam Metheny by Richard
 Signature of Claimant / Representative

Sworn to and subscribed before me at Little Rock AR
 City & State
 on this 2ND day of Sept, 2011.
 day month year

My Commission Expires 1/28/2014

Barbara Bambrick
 Signature of Notary Public

STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim \$?

Claim No. 12-0196-CC

Kenny & Pamela Metheny Claimant vs. Phillip J. Duncan, Attorney Claimant
UA-Medical Sciences Respondent vs. Sherri L. Robinson, Attorney Respondent
State of Arkansas Respondent
Date Filed September 2, 2011 Type of Claim Negligence, Personal Injury

FINDING OF FACTS

The Claims Commission hereby unanimously denies Respondent's "Motion for Reconsideration" and orders this claim to be set for hearing.

IT IS SO ORDERED.

(See Back of Opinion Form)

CONCLUSION

The Claims Commission hereby unanimously denies Respondent's "Motion for Reconsideration" and orders this claim to be set for hearing.

Date of Hearing May 14, 2015

Date of Disposition May 14, 2015

H Moore Chairman
W. Stoshen Commissioner
Jal... Commissioner

**Appeal of any final Claims Commission decision is only to the Arkansas General Assembly as provided by Act #33 of 1997 and as found in Arkansas Code Annotated §19-10-211.

STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim \$

Claim No. 12-0196-CC

Kenny & Pamela Metheny, Individually &
Co-Conservators of Cody Ryan Metheny **Claimant**

Attorneys Phillip Duncan, Attorney **Claimant**

vs.
University of AR for Medical Sciences
Respondent

Sherri Robinson, Attorney
Respondent

State of Arkansas September 2, 2011

Negligence/Personal Injury

Date Filed

Type of Claim

FINDING OF FACTS

This claim was filed for negligence/personal injury in an unspecified amount against the University of Arkansas for Medical Science. Present at a hearing October 14, 2015, was the Claimant, represented by Phillip Duncan, Attorney, and the Respondent, represented by Sherri Robinson, Attorney.

1. Claimants, Pamela and Kenny Metheny, are the parents of Cody Ryan Metheny (entire record, *passim*).
2. On August 2, 2014, Cody Ryan Metheny was a fifteen year old child (entire record, *passim*).
3. Cody Ryan Metheny was treated for epileptic seizures by Dr. Badih Adada, and other physicians at the University of Arkansas Medical Sciences, Pediatric Division, which is located at Arkansas Children's Hospital ("ACH") (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates).
4. In 2004, Dr. Badih Adada was an employee of the State of Arkansas at the University of Arkansas Medical Sciences when he operated on Cody Metheny (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett and UAMS neurosurgery and affiliation agreement with ACH, UAMS correspondence with Dr. Badih Adada, Deposition and Trial Testimony of Dr. Gregory Sharp).


(See Back of Opinion Form)

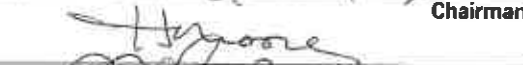
CONCLUSION

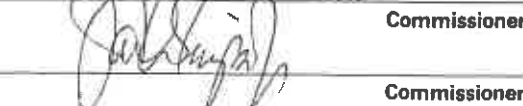
The Claims Commission hereby awards this claim in the amount of \$2,000,000.00 and will include the claim in a claims bill to be submitted to the 91st General Assembly, Arkansas State Legislature 2016 Fiscal Session, for subsequent approval and payment.

Date of Hearing October 14, 2015

Date of Disposition October 30, 2015


Chairman


Commissioner


Commissioner

75

5. Dr. Adada was employed as an UAMS physician, professor, teacher and department head (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett and UAMS agreement with ACH, UAMS correspondence with Dr. Badih Adada).
6. Dr. Adada was the Chief of Pediatric Neurosurgery at UAMS's pediatric affiliate and alter-ego, ACH, at the time Cody Ryan Metheny was treated (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett, UAMS agreement with ACH, UAMS and ACH documents, UAMS correspondence with Dr. Badih Adada).
7. Dr. Adada was the Chief of Pediatric Neurosurgery for UAMS at the time of the occurrence at issue in this case (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett, UAMS agreement with ACH, UAMS and ACH documents).
8. When a UAMS resident assists Dr. Adada in surgery, in addition to Dr. Adada's role to treat and take care of his pediatric patient as attending surgeon, it is his role to teach, train and supervise the UAMS resident (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Dr. Ali Raja, Testimony of Arthur Shorr, Trial Testimony of Dr. Gregory Sharp, UAMS agreement with ACH, Medical by-laws, UAMS and ACH documents), including completing the discharge summary.
9. Administratively, UAMS, through its pediatric affiliate and alter-ego ACH, and Chief of Pediatric Neurosurgery, Dr. Adada, and UAMS resident assistant neurosurgeon, Dr. Raja, operated on Cody Ryan Metheny on August 2, 2004, to remove a right-sided lesion. This surgery was performed during a teaching and residency neurosurgery program (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett, UAMS agreement with ACH, UAMS and ACH documents).
10. UAMS is a division of the University of Arkansas. UAMS and ACH have been affiliated through formal agreement and by relationship since 1982, because ACH did not have a Pediatric Division. UAMS became the pediatric clinical care partner, affiliate and alter-ego of ACH for treating and operating on children in ACH (Deposition and trial testimony of Dr. Johnathon Bates, Vicki Bennett, Deposition of Bonnie Taylor, UAMS agreement with ACH, FTC Advisory Opinion, UAMS Medical Student materials, UAMS organizational charts, UAMS and ACH documents and UAMS correspondence).

11. The formal affiliation between UAMS and ACH is both contractual and administrative and creates a direct patient relationship between UAMS and pediatric patients at ACH who are treated by UAMS physicians and faculty, as employees of the State of Arkansas (Deposition and trial testimony of Dr. Johnathon Bates, Vicki Bennett, Deposition of Bonnie Taylor, UAMS agreement with ACH, FTC Advisory Opinion and UAMS and ACH documents).
12. The medical director at the time of the occurrence at issue in this case was the same for UAMS and ACH, Dr. Bonnie Taylor, M.D (Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Bonnie Taylor, UAMS agreement with ACH, UAMS correspondence with Bonnie Taylor, UAMS Medical Student materials, UAMS organizational charts, UAMS and ACH documents and UAMS correspondence).
13. The medical director is hired through a joint process between UAMS and ACH. The medical director is responsible for the medical staff comprised of UAMS physicians and faculty, hospital clinical policies and patient care, including sentinel events and root cause analysis and completion of the medical record (Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Bonnie Taylor, UAMS agreement with ACH, UAMS correspondence with Bonnie Taylor, UAMS Medical Student materials, UAMS organizational charts, UAMS and ACH documents and UAMS correspondence, ACH medical record, ACH medical policies).
14. UAMS pays Dr. Badih Adada's and other UAMS physicians' salaries because the physicians are State of Arkansas employees. Pursuant to agreement and testimony, Dr. Badih Adada was, at all times while taking care of his patients at ACH, an employee of UAMS (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Trial Testimony of Dr. Gregory Sharp, Vicki Bennett and UAMS neurosurgery and affiliation agreement with ACH, UAMS correspondence with Dr. Badih Adada).
15. UAMS doctors provide the pediatric care at its partner, ACH (Deposition and trial testimony of Dr. Badih Adada, Dr. Johnathon Bates, Vicki Bennett and UAMS neurosurgery and affiliation agreement with ACH, UAMS correspondence with Dr. Badih Adada, Deposition of Dr. James Grady Crosland, Deposition of Dr. Gregory Sharp, Deposition of Dr. Ali Raja, Deposition of Manual Gorrin-Rivas, Deposition of Scott Suhrer).
16. UAMS houses its pediatric neurosurgery division at ACH.
17. ACH is the Arkansas teaching and residency hospital for treatment of children by UAMS.

18. UAMS faculty members/doctors, chiefs of professional services and professional staff administratively function with ACH performing the professional and administrative functions for medical care and judgment at the State's children's hospital.

19. UAMS doctors draft medical policies, provide medical judgment, clinic care, operate on children, supervise, teach and train UAMS residents during pediatric care.

20. UAMS's Department of Pediatrics, ACH, offer a wide range of pediatric medicine programs caring for more than 10,000 inpatient admissions.

21. UAMS represents, relates and holds ACH out to the public as its partner, pediatric affiliate and alter-ego in the State of Arkansas. For example, "UAMS Doctors. Arkansas Children's Hospital. Two Great Partners."

22. UAMS further represents its partnership with ACH on its webpage:

"Through our partnership with Arkansas Children's Hospital, our services include pediatric training, clinical assessment, diagnosis and treatment of acute and chronic disorders, and cutting-edge research on techniques to enhance a child's home and medical environment."

23. The United States Federal Government has recognized the close relationship between UAMS and ACH for pediatric care in Arkansas. An official Federal Trade Commission ("FTC") advisory opinion issued on March 13, 2003 (thirteen months before the multiple brain surgeries) affirmed the following facts:

- a. UAMS and ACH established a joint venture to care for children at the outpatient clinics operated on the ACH campus;
- b. UAMS and ACH have a "common purpose" to care for the same pediatric patients;
- c. UAMS and ACH deliver patient care for a common patient population;
- d. UAMS's Department of Pediatrics is located on the ACH campus;
- e. UAMS and ACH coordinate their clinical services, education programs, and research;
- f. "All the clinics are staffed by UAMS physicians, and UAMS personnel have a direct role in the clinical management of ACH...";
- g. UAMS physicians serve as medical directors over ACH departments and over ACH; and

h. UAMS clinically manages ACH and its patients and is administratively responsible for the welfare and safety of children injured by doctors at ACH.

24. Medical testimony under oath regarding UAMS and ACH, as alter-egos, and the interrelationship between the two entities is as follows:

Pursuant to her testimony, Bonnie Taylor MD, a UAMS professor serves as Medical Director for ACH and Senior Vice-President. All the medical committees at ACH are staffed by UAMS employee physicians. The medical committees are charged with the formation and development of all medical care policies, procedures and procedure at ACH. All medical committees function under the direction of Dr. Taylor in her capacity as Medical Director. All of the physicians were subject to her clinical administrative oversight. The Medical Director for ACH is also required to function as Chairman of UAMS' Department of Pediatrics and as UAMS faculty. As such, the Medical Director for ACH is constructively appointed by the UAMS Chancellor. (Deposition of Dr. Bonnie Taylor, Deposition and trial testimony of Dr. Johnathon Bates, agreement between UAMS and ACH, medical policies and ACH Medical Staff Rules and Regulations).

25. Dr. Badih Adada, as an employee of the State of Arkansas, had a direct patient relationship with Cody Metheny. (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition of Vicki Bennett). On August 2, 2004, the UAMS Chief of Pediatric Neurosurgery, Dr. Badih Adada, while teaching a UAMS resident physician, Ali Raja, opened a large brain flap and entered deep into the wrong side of Cody Metheny's brain. (Deposition and trial testimony of Dr. Badih Adada, Deposition of Dr. Ali Raja, Deposition of Dr. James Grady Crosland, Deposition of Dr. Johnathon Bates, Dr. Stephen Nokes, medical records). Dr. Adada removed a large section of the healthy brain on the incorrect side, which caused extensive and permanent, irreparable harm and removed brain tissue on both sides of Cody Metheny's brain, including, but not limited to the amygdala and hippocampus areas of the brain. (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Ali Raja, Testimony of Arthur Shorr, Deposition and trial testimony of Dr. Gregory O'Shanick, Deposition and trial testimony of Dr. Peter Patrick, Deposition of Dr. Steven Nokes).

26. After the multiple hour surgery on the wrong side of the brain, the patient was turned over, re-prepped and, even though contra-indicated, surgery took place on the other side of his brain thereby damaging similar areas on both sides of Cody's brain (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Ali Raja, Testimony of Arthur Shorr, Deposition and trial testimony of Dr. Gregory O'Shanick, Deposition and trial testimony of Dr. Peter Patrick, Deposition of Dr. Steven Nokes).

27. Cody had significant brain tissue removed from the amygdala and hippocampus area on both hemispheres of his brain (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Ali Raja, Testimony of Arthur Shorr, Deposition and trial testimony of Dr. Gregory O'Shanick, Deposition and trial testimony of Dr. Peter Patrick, Deposition of Dr. Steven Nokes).
28. During the first, wrong-sided surgery, UAMS physician and state employee, Dr. Adada, and his assistant neurosurgeon, UAMS resident physician Dr. Ali Raja, conferred and privately discussed the wrong-sided surgery when it occurred approximately three and half hours into the surgery when Dr. Adada realized he was on the wrong side and into the left side of Cody's brain. (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland).
29. However, neither UAMS physician disclosed the wrong side brain removal to the parents of Cody Metheny. Indeed, to the contrary, Dr. Adada testified that he affirmatively told the parents he did not harm the brain. Neither doctor obtained informed consent from Cody's parents to continue to operate on the correct side of Cody's brain after the erroneous wrong side surgery. (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Deposition testimony of Dr. John Shershow, medical records).
30. Pamela and Kenny Metheny were never provided the opportunity to seek immediate treatment from another healthcare provider or to decline the subsequent surgery after the botched surgery (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).
31. UAMS physician, and head of pediatrics, Dr. Bonnie Taylor, who was the Medical Director for ACH, testified under oath in her deposition that she knew of the wrong-side brain surgery within one day of its occurrence (Deposition of Dr. Bonnie Taylor).
32. However, Dr. Taylor never met with the parents of Cody Metheny. (Deposition of Dr. Bonnie Taylor). Dr. Taylor never looked at Cody Metheny's medical documentation or his chart. *Id.* Dr. Taylor never had any contact with anyone directly involved in the case. *Id.* Dr. Taylor never disclosed or revealed any information about the wrong-sided surgery nor follow up at any time with Cody's parents. *Id.*

33. UAMS Professor and state employee, Dr. Badih Adada, dictated and deliberately created a false operative note 28 days after the wrong-sided surgery was performed, and he waited 49 days after the surgery to sign the dictated, false operative note (Deposition and trial testimony of Dr. Badih Adada).
34. Dr. Badih Adada admittedly violated hospital policy for medical record completion and timeliness (Deposition and trial testimony of Dr. Badih Adada).
35. The truth and extent of the brain damage was affirmatively concealed from the parents and was never written in any medical records. (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).
36. A state employee and UAMS resident student being trained and supervised during the occurrence, Dr. Ali Raja, affirmatively concealed and did not disclose the wrong side brain removal in his pediatric patient discharge summary (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).
37. The truth and extent of the wrong-sided brain surgery was never accurately nor adequately disclosed in any medical chart, document, note, or any other type of medical record, which prevented rehabilitation until the Metheny's learned of the missing brain from the wrong side from a MRI taken about fifteen months later provided by Dr. Stephen Nokes, a radiologist at Baptist Health (Deposition and trial testimony of Dr. Badih Adada, Deposition testimony of Dr. Ali Raja, Trial testimony of Dr. Gregory Sharp, Deposition testimony of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Johnathon Bates, Testimony of Arthur Shorr, Deposition testimony of Dr. John Shershow, medical records).
38. In depositions and the circuit trial taken during the civil suit filed in Pulaski County Circuit Court after the surgeries were performed, Dr. Badih Adada admitted he was a state employee, that he was liable for committing severe malpractice when he negligently removed a large, healthy section from the wrong side of Cody's brain and admitted that he was responsible for his patient. He further admitted that he did not disclose the damage to the wrong side of the brain (Depositions and trial testimony of Dr. Badih Adada).

39. In the depositions taken during the civil suit filed in Pulaski County Circuit Court after the surgeries were performed, Dr. Badih Adada admitted that he electronically dictated an operative report that was patently false. The falseness of the operative note was only revealed by a lawsuit and formal deposition (Deposition of Dr. Badih Adada).
40. Medical testimony under oath is that, with respect to compliance with the Joint Commission in Accreditation of Healthcare Organizations ("JCAHO"), it was a former surveyor and teacher at JCAHO's most egregious case of JCAHO violations, a white-wash of the medical records and medical fraud. (Testimony of Arthur Shorr, Deposition of Dr. John Shershow).
41. It is universally medically accepted that removing brain tissue on both sides of the brain, particularly the amygdala, hippocampus area, should never be done and will in high likelihood cause serious and permanent disability to the affected patient (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).
42. In particular, removal of both sides of the brain, including the amygdala and hippocampus will cause serious and permanent harm to a patient (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).
43. Medical testimony under oath is that the wrong-sided brain surgeries did cause permanent injury, including loss of enjoyment of life, cognitive loss, loss of natural drive, memory problems, emotional problems, psychotic behavior, hallucinations and other psychotropic events and episodes (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).
44. The substantial evidence shows the injuries caused by the wrong-sided surgery have resulted in Cody Metheny having to be cared for in an institutional setting (Deposition and Trial Testimony, *passim*).
45. The institutional setting included extensive neuro-rehabilitation in Virginia Beach (Deposition and Trial Testimony, *passim*).
46. Medical testimony under oath is that Cody Metheny will now need structured living for the rest of his life, and he will never be self-sufficient ((Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).
47. According to medical testimony, the likelihood of early onset dementia, Alzheimer's and these type of brain-related diseases are more probable than not and are the permanent results of this type of wrong-sided surgery (Dr. Gregory O' Shannick, Dr. Peter Patrick, various medical testimony, *passim*).

48. Substantial evidence shows there was a complete administrative breakdown and institutional failure by UAMS, and its partner and pediatric affiliate and alter-ego ACH, to provide truthful information about the wrong-sided surgery (Dr. Badih Adada, Dr. Ali Raja, Dr. James Grady Crosland, Dr. Gregory Sharp, Dr. Scott Suhrer, Dr. Gorrin-Rivas, Dr. Bonnie Taylor, Dr. Johnathon Bates, Vickie Bennett, Mary McDaniel).

49. Although administrator, including Chief of Neurosurgery, Dr. Badih Adada, knew of the wrong-sided surgery at the UAMS Department of Pediatrics, its administrators went home without notifying the family, following up with the family, documenting the record, and assuring the continuity of medical care while Cody Metheny was a patient and in post-surgical care, all of which is unequivocally required by the rules and standard medical treatment (Deposition and trial testimony of Dr. Badih Adada, Deposition of Dr. Ali Raja, Deposition of Dr. James Grady Crosland, Deposition and trial testimony of Dr. Gregory Sharp, Deposition of Dr. Scott Suhrer, Deposition of Dr. Gorrin-Rivas, Deposition of Dr. Bonnie Taylor, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Vickie Bennett, Deposition of Mary McDaniel).

50. UAMS's systemic failure included the violation of the UAMS "time-out" policy, required by JCAHO, which states, each person in the operating room was required to stop, huddle up, and acknowledge individually and as a group that: this is the correct patient; the correct procedure; the correct position for the patient; the correct side, site and/or body part is being operated upon by the UAMS surgeon. According to medical testimony, this should happen in every single case (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. John Shershow, Testimony of Arthur Shorr, medical records).

51. UAMS also violated the "sentinel event" policy, which constitutes a failure to disclose, suppression of a serious medical error and cover up. When a major event of negligence or death occurs at a hospital, it is referred to as a "sentinel event" and is required to be reported to certification authorities, such as JCAHO. Dr. Badih Adada, Dr. Johnathon Bates and Vickie Bennett recognized the wrong-sided surgeries as a sentinel event. However, no sentinel event was reported to the accreditation authority, JCAHO (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Vicki Bennett, Trial Testimony of Cheryl Ray, Deposition and trial testimony of Dr. Johnathon Bates).

52. Medical testimony under oath explains how UAMS covered up Cody Metheny's wrong sided-surgery and its importance in this community, stating:

The further direction and control exerted by UAMS physicians over the follow-up documentation, including untimely documentation and ill-conceived futile attempt to create a "white-wash" in the medical record, to suggest that there was no indication of a wrong-side, invasive and permanently harmful surgery. The intent was to prevent any objective review of the medical record evidenced by the non-disclosure of accurate facts to the parents, lack of transparency and accuracy, or objective documentation. **This type of cover-up and failure to document and conceal from families is not supposed to occur at any accredited hospital let alone a tertiary care teaching institution. Such behavior undermines the community's investment and trust in UAMS' role in the teaching and training of the next generation of medical and healthcare professionals,** and public trust in the partnership between the UAMS and ACH. Further it calls into question the ability of ACH to provide "quality, patient care" which it purports to provide tertiary medical and patient care equivalent or better than other children's hospitals around the country. (emphasis added) (Arthur Shorr Affidavit).

53. Substantial evidence and medical testimony under oath show Cody Metheny was directly damaged by the UAMS's systemic breakdown and failure to disclose the wrong-sided surgery and its extent because it prevented Cody from rehabbing his brain within one year of his traumatic injury, which according to medical testimony, is the most important time for the type of neurorehabilitation Cody needed (Deposition and trial testimony of Dr. Gregory O' Shannick, Deposition and trial testimony of Dr. Peter Patrick).

54. During the multiple brain surgeries, medical records were created with inaccurate information. The truth behind the multiple surgeries was not revealed or disclosed to Cody's parents, Pam and Kenny Metheny for over one year, and only after a lawsuit was filed, depositions were taken and medical doctors from Baptist Health reviewed the medical information contained (or lack thereof) in the UAMS/ACH medical records (Deposition and trial testimony of Dr. Badih Adada, Deposition and trial testimony of Dr. Johnathon Bates, Deposition of Dr. Bonnie, Taylor, Deposition and trial testimony of Kenny and Pamela Metheny, Deposition and trial testimony of Dr. John Shershow, Testimony of Arthur Shorr, medical records).

55. The litigation in this case lasted over ten years from the time of Cody's wrong-sided surgery.

56. The case went to a jury trial in Pulaski County, Arkansas and lasted for two weeks. After numerous witnesses, the in-depth review of enormous amounts of medical information, including the medical records, charts, notes, and listening to medical testimony at length. Evidence was presented that damages were in excess of \$20 million. The jury awarded a verdict for \$20 million, which was entered in favor of the Claimants on September 24, 2010 (Jury verdict & *Pro Assurance v. Metheny* appeal).

57. Attorneys for the pediatric affiliate ACH appealed the jury verdict and argued that ACH, as non-profit, only had to pay up to the amount of its insurance. ACH was successful in reducing the jury verdict to the amount of private insurance available, which left a shortfall of over \$8 million for the permanent, disabling damages experienced by Cody Metheny (Jury verdict and *Pro Assurance v. Metheny* appeal).

58. Claimants exhausted their remedies against tortfeasors with private insurance, including the private insurance policy of state employee, Dr. Badih Adada, and the capped insurance for UAMS pediatric affiliate and partner in pediatric clinical care, ACH. The private insurance, which is \$8 million less than the jury verdict awarded Cody Metheny for his damages, is inadequate to address the permanent, disabling damages experienced by Cody Metheny family.

2. Conclusions of Law

59. Negligence is defined to mean the failure to do something, which a reasonably careful person would do, or the doing of something which a reasonably careful person would not do, under circumstances similar to those shown by the evidence in this case. See *Wallace v. Broyles*, 331 Ark. 58, 66, 961 S.W.2d 712, 715 (1998). See ARK. MODEL JURY INST. (AMI) -- Civil 301 (2015 ed)

60. To constitute negligence, an act must be one from which a reasonably careful person would foresee such an appreciable risk of harm to others as to cause him not to do the act, or to do it in a more careful manner. *Id.* The Arkansas Supreme Court has held that to constitute actionable negligence, it is not necessary that the actor foresee the particular injury which occurred, only that the actor reasonably foresee an appreciable risk of harm to others. *Id.* (citing *Jordan v. Adams*, 259 Ark. 407, 533 S.W.2d 210 (1976)) (emphasis supplied).

61. A physician and medical care provider in Arkansas has a duty of care owed to a patient regarding medical treatment, diagnosis, surgery or operation and obtaining informed consent to perform a medical procedure, including disclosing all risks to the patient or the patient's representative.

62. The physician and medical care provider must possess and apply with reasonable care the degree of skill and learning ordinarily possessed and used by members of the provider's profession where the practice is located. A breach and failure of this standard is negligence. See AMI 1501.

63. Arkansas law is clear that if the physician or medical care provider (such as Dr. Adada) is an employee of the defendant employer (UAMS), then the defendant employer is vicariously liable under the doctrine of *respondeat superior* for the negligence of the medical care provider. *Chicago, R.I. and*

P.R. Co. v. Britt, 189 Ark. 571, 74 S.W.2d 398 (1934) (finding railroad with contract with Little Rock was responsible as employer of surgeon who committed malpractice). Here UAMS physician Dr. Adada admittedly committed severe malpractice. Dr. Adada and other UAMS physicians and State of Arkansas employees altered medical record or provided incomplete and untrue information and failed to disclose material facts. Under the doctrine of *respondeat superior*, these state employees' negligence and tortious behavior binds UAMS. Consequently, under Arkansas law, UAMS is liable for the admitted negligence by UAMS doctors. *Id.*

64. Under Arkansas law, neither Dr. Badih Adada nor any of the other physicians in this case was employed by Arkansas Children's Hospital. Rather, Dr. Adada and the other physicians were employed by the University of Arkansas Medical Sciences at the time of the occurrence at issue in this case.

65. Furthermore, UAMS owed a general duty of care to its common patient population, including Cody Metheny. UAMS knows its doctors, residents and fellows will be operating on pediatric patients and involved in education and training in their specialty at ACH. *See County of Riverside v. Loma Linda University*, 118 Cal.App.3d 300, 173 Cal.Rptr. 371 (1981) ("[T]he university owed a duty to patients who were under the care and treatment of residents to see that the residents received proper education and training in their specialty and proper supervision over the clinical aspect of their training.").

66. Here, UAMS through its partner, affiliate, alter-ego and agent, ACH, breached a general duty of care owed to Cody Metheny for several reasons:

- (1) First, UAMS and ACH's relationship was intended to affect their joint patients;
- (2) Second, UAMS physicians, residents and fellows were known to engage in patient care at its UAMS Pediatric Department located on its ACH campus, thus, harm was foreseeable;
- (3) Third, there is absolute certainty that Cody Metheny was permanently and severely harmed by UAMS conduct occurring at UAMS Department of Pediatrics and admitted liability by UAMS employee Dr. Badih Adada;
- (4) Fourth, there is a closeness of the relationship between UAMS systemic breakdown, involving the "time-out" policy and care and treatment of Cody Metheny at UAMS Pediatric Department;
- (5) Fifth, there was a failure to train and instruct the time-out policy so UAMS employees called and followed a proper timeout procedure at UAMS Pediatric Department;
- (6) Sixth, the UAMS employees failed to properly document the wrong-sided surgeries; and

(7) A determination that UAMS breached its duty of care in its Pediatric Department will serve to improve patient care and benefit the medical school, hospital, professors, interns and residents.¹

67. UAMS owed a professional duty of care toward Cody, who was a joint and common UAMS/ACH patient, at all relevant times. Moreover, under Arkansas law, UAMS owed a fiduciary duty toward Cody Metheny and his parents, including a duty of full and fair disclosure of all material facts about Cody's surgery and medical condition.

68. A fiduciary duty is the highest duty owed at law. BLACK'S LAW DICTIONARY, at 625 (6th ed. 1990). Medical providers universally and in Arkansas have a "special, confidential relationship" with a patient under well-established law, and, are, therefore, fiduciaries to the patient. *See, e.g., Howard v. Northwest Ark. Surgical Clinic, P.A.*, 324 Ark. 375, 921 S.W.2d 596 (1996) (finding fiduciary duty for doctor and clinic where doctor worked); *Roberts v. Francis, M.D.*, 128 F.3d 647, 649 (1997) (citing *Howard* and other Arkansas cases). By virtue of Cody's treatment by UAMS Department of Pediatric physicians, there is a special, confidential relationship requiring an utmost degree and duty of care, duty of honesty, good faith, loyalty and duty of full disclosure. *See id;* *see also* BRILL, LAW OF DAMAGES § *Fiduciary relationships* at 258; *Deitsch v. Tillery*, 309 Ark. 401, 833 S.W.2d 760 (1992) (failure to disclose is a breach of duty and considered outrageous when involving children).

69. In *Roberts*, the Eighth Circuit cited to Arkansas cases and law holding there was a special, confidential relationship with a patient where a surgical error occurred (ovary removed), which the patient did not know and would not know, but for the disclosure of this factual information by medical providers at the time of the medical error. *Id.* at 649. Full disclosure of the factual information and medical error to the patient was required of the medical provider (i.e., an affirmative duty to speak). The *Roberts* Court stated:

In this case, we find that Dr. Francis' fraudulent concealment of his alleged medical malpractice tolls the statute of limitations. It is undisputed that Dr. Francis removed appellant's only remaining ovary and failed to disclose this information to her. *See Howard v. Northwest Ark. Surgical Clinic, P.A.*, 324 Ark. 375, 921 S.W.2d 596, 599 (1996) (a physician's knowledge of the alleged wrong is a necessary prerequisite to tolling the statute) (citations omitted). In *Union National Bank of Little Rock v. Farmers Bank, Hamburg Arkansas*, 786 F.2d 881 (8th Cir.1986), we stated: "**Under Arkansas law, a party may have an obligation to speak rather than remain silent, when a failure to speak is the equivalent of fraudulent concealment.**" *Id.* at 887 (citing *Berkeley Pump Co. v. Reed-Joseph Land Co.*, 279 Ark. 384, 653 S.W.2d 128 (1983)). With respect to when a duty to speak arises, the Arkansas Supreme Court has stated, "[t]he duty of disclosure ... arises where one person is in [a] position to have and to exercise influence over another who reposes confidence in him whether a fiduciary relationship in the strict sense of the term exists between them or not." *Hanson Motor Co. v. Young*, 223 Ark. 191, 265 S.W.2d 501, 504 (1954)

¹ *Id.* (citation omitted) (emphasis added). *Id.* at 649.

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70. In this case, the UAMS Chief of Pediatric Neurosurgery, the Medical Director of UAMS, a UAMS employee and resident, and other UAMS administration all knew of Cody's wrong-sided surgery and fraudulently concealed the facts of the surgery when each respective knowledgeable party unilaterally chose to remain silent.

71. Arkansas law has a strong public policy against the concealment, omission and suppression of material evidence with regard to medical care and the treatment of a human, which infers negligence or wrongful conduct. See, e.g., *Smith v United States*, 128 F.Supp.2d 1227, 1233-34 (E.D. Ark. 2000) (finding that physician had failed to dictate a post-surgical note when required by standard medical procedure and public policy); *Carr v. St. Paul Fire & Marine Ins. Co.*, 384 F.Supp. 821, 830 (W.D. Ark. 1974) (recognizing that jury could infer negligence over record that was not retained).

72. Moreover, under Arkansas law, a person commits the offense of tampering with physical evidence if he or she alters, destroys, suppresses, removes or conceals any record, document, or thing with the purpose of impairing its verity, legibility, or availability in any official proceeding or investigation. Ark. Code Ann. § 5-53-111.

73. UAMS, and its physicians, had an affirmative duty of patient care and fiduciary duty to fully disclose all factual information to Cody Metheny's parents, as Cody's guardians and co-conservators. UAMS failed to do so.

74. The Claimants, as the result of direct negligence of UAMS, and a failure to disclose and reveal material medical information, experienced a serious and permanent loss and life-changing event to their son Cody Metheny, resulting in damages award of \$20,000,000, by a Pulaski County jury.

75. The Arkansas State Claims Commission finds UAMS is negligent and responsible for the harm sustained by the Claimants. However, it is not bound by the amount of damages determined by the Pulaski County jury. The damages as determined by the Pulaski County jury were based in part on a care plan for Cody Metheny which has since been determined by Mr. Metheny's parents. The Arkansas State Claims Commission still believes that the damages paid through the insurance coverages hereinabove set forth are still inadequate to compensate Cody Metheny and his family and fixes the damages to be paid by UAMS in the amount of \$2,000,000.00.

The Claims Commission hereby awards this claim **in the amount of \$2,000,000.00 and will be include the claim in a claims bill to be the submitted to the 91st General Assembly, Arkansas State Legislature 2015 Fiscal Session, for subsequent approval and payment.**

IT IS SO ORDERED

IN THE ARKANSAS STATE CLAIMS COMMISSION

**KENNY & PAMELA METHENY,
GUARDIAN OF CODY METHENY**

**RECEIVED
CLAIMANTS**

V.

CASE NO. 12-0196-CC

**UNIVERSITY OF ARKANSAS FOR
MEDICAL SCIENCES**

RESPONDENT

RESPONDENT'S NOTICE OF APPEAL

Comes now, Respondent, University of Arkansas for Medical Sciences, and for its Notice of Appeal, states:

1. This matter was heard by the Arkansas State Claims Commission on October 14, 2015.
2. The Commission issued Findings of Fact and Conclusions of Law in favor of Claimants on November 13, 2015 and awarded Claimants \$2,000,000.
3. The Commission's decision is contrary to the evidence presented in the hearing and post-hearing briefs and inconsistent with the applicable Arkansas law.
4. Pursuant to Ark. Code Ann. § 19-10-211(b)(2), Respondent timely filed a motion for reconsideration which the Commission denied on January 14, 2016.
5. Pursuant to Ark. Code Ann. § 19-10-211(b)(3), Respondent now timely files this notice of appeal to the Arkansas General Assembly.

Respectfully submitted,

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES,
Respondent

By:



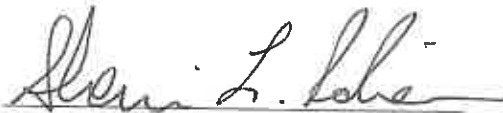
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(501) 686-7608
Srobinson3@uams.edu

Attorney for Respondent

CERTIFICATE OF SERVICE

I, Sherri L. Robinson, do hereby certify that a copy of the foregoing pleading has been served on claimants herein by mailing a copy of same, by U.S. Mail, postage prepaid, this 1st day of February, 2016, addressed to the following:

Richard Quintus
Phillip J. Duncan
DUNCAN FIRM, P.A.
Three Financial Centre
900 S. Shackelford, Suite 725
Little Rock, AR 72211



Sherri L. Robinson

**BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas**

FEB 03 2016

PAMELA and KENNY METHENY,
Individually, and as Co-Conservators
for CODY RYAN METHENY

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RECEIVED

Claimants,

v.

Claim No. #12-0196-CC

UNIVERSITY OF ARKANSAS FOR
MEDICAL SCIENCES, UAMS

Respondent

CLAIMANTS' NOTICE OF APPEAL

Come now Claimants Pamela and Kenny Metheny, parents and Co-Conservators of Cody Metheny, and hereby file this *Notice of Appeal* from the Claims Commission October 14, 2015 decision, November 13, 2015 written decision and docket opinion and the January 14, 2016 decision in this case making all orders final for review by the General Assembly.

Claimants respectfully request all findings of facts and conclusions of law of the Honorable Arkansas State Claims Commission *be affirmed*; additionally Claimants respectfully reserve the right to request an increase of the award, if warranted, before the Arkansas General Assembly.

Respectfully submitted,



By:

DUNCAN FIRM, P.A
Phillip J. Duncan, ABN #74039
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CERTIFICATE OF SERVICE

I, the undersigned counsel for the Claimants, hereby certify that a true and correct copy of the foregoing *Claimants' Notice of Appeal* was served upon the following counsel of record:

Sherri L. Robinson, Esq.
Associate General Counsel, UAMS
University of Arkansas for Medical Sciences
4301 West Markham, Slot 860
Little Rock, AR 72205
Counsel for Respondent UAMS

On this 3rd day of February, 2016.



Phillip Duncan