CATHY ANN BEVINS	*	IN THE
PLAINTIFF	*	CIRCUIT COURT
V.	*	FOR
HANH TRAN, M.D., ET AL.	*	BALTIMORE COUNTY
DEFENDANTS	*	CASE NO. C-05-7400

1516 Mem H Blvd
Balt, MD 21222

* * * * *

COMPLAINT AND PRAYER FOR JURY TRIAL

Cathy Ann Bevins (hereinafter "Bevins"), Plaintiff, by her attorneys, Michael Paul Smith, and Bodie, Nagle, Dolina, Smith & Hobbs, P.A., sues Hanh Tran, M.D. (hereinafter "Tran"), Franklin Square Hospital Center, Inc. (hereinafter "Franklin Square"), and Medstar Healthcare, Inc. (hereinafter "Medstar"), Defendants, and states:

1. Plaintiff resides at 7600 Poplar Avenue, Baltimore, Baltimore County, Maryland 21224.

2. Defendant Tran is a health care provider who regularly conducts business in the State of Maryland.

3. Franklin Square is located in Baltimore County.

4. Medstar regularly conducts business in Baltimore County.

5. The venue for this claim is proper in Baltimore County.

6. At the time of the incident which is the subject of this suit, Defendant Tran was employed by and/or was an agent of Franklin Square and/or Medstar.

7. On August 21, 2002 Plaintiff Bevins underwent a total abdominal hysterectomy at Franklin Square, a member of Medstar. A copy of the Discharge Summary is attached hereto as Exhibit A.

8. The Discharge Summary, page 2, indicated on postoperative day three that Bevins return of bowel function was slow and was not advanced to a regular diet until day three. She also developed a temperature of 100.2°. The notes indicate a contributory factor for these problems could have been due to the fact that Bevins was catheterized several times due to postoperative urinary retention. She was discharged on day three with a Foley catheter in place. See Exhibit A, page 2.

9. On August 24, 2002, Bevins was discharged from Franklin Square and according to the Follow-up note contained on page 2 of the Discharge Summary attached hereto as Exhibit A, Bevins was to return to see Dr. Tran in one week for staple removal and catheter removal.

10. After her release from the hospital on August 24, 2002 and until October 1, 2002, Bevins saw Tran for several visits, during which Bevins repeatedly complained of problems with urination, intense pain, and severe leakage. See Tran's Progress Notes attached, collectively, hereto as Exhibit B.

11. In early September 2002, Tran noted Bevins was experiencing bladder infections, in addition to other problems not yet discovered by Tran. See Exhibit B.

12. On October 11, 2002, an intravenous pyelography was performed on Bevins. See. Dr. Bertan Ozgun's October 11, 2002 report of X-ray Intravenous Pyelography attached hereto as Exhibit C. As a result, Tran referred Bevins to Dr. William Dowling, a urologist, for a cystoscopy.

13. Dr. Dowling performed a cystoscopy on November 12, 2002 on Bevins and discovered two vesicovaginal fistula, which he fulgurated and inserted a catheter. See Dr. Dowling's Operative Procedure Note dated November 12, 2002 attached hereto as Exhibit D.

14. The following day, Bevins noticed the leakage of urine from the vagina had resumed, as well as intense bladder spasms. See Dr. Dowling's note from a telephone call attached hereto as Exhibit E.

15. Bevins returned to Dr. Dowling after two weeks for removal of her catheter.

16. Dr. Dowling's notes dated November 20, 2002 suggesting that the fulguration was not successful and referred Bevins to Dr. Edward Wright, a urologist at Johns Hopkins Bayview. See Follow-up Note attached hereto as Exhibit F.

17. Dr. Wright performed another cystoscopy on February 4, 2003, and discovered three vesicovaginal fistula, and counseled her as to repair and the procedure that would be required. See Dr. Wright's report dated February 4, 2003 attached hereto as Exhibit G.

18. On February 5, 2003, Dr. Wright performed an eight hour surgery on Bevins to repair the three fistula. As a result of this surgery, her condition continues to be manageable, although now she urinates more frequently and urination is a matter of urgency. She has lost some bladder control. See Operative Report dated February 5, 2003 attached hereto as Exhibit H.

19. Bevins was, in no way, contributorily negligent.

20. In the seven months between the hysterectomy and Bevins' recovery from the February 5, 2003 surgery at Johns Hopkins Bayview, she was unable to urinate for much of the time and she had to wear a catheter and when she did not have a catheter, she was faced with the constant leakage of urine.

21. During this time, Bevins suffered from pain, was forced to wear Depend diapers and was unable to care for her husband and children as she normally would.

22. Prior to the hysterectomy, Bevins and her husband enjoyed a very close relationship and her condition kept them from being intimate for approximately seven months.

23. As a result of the surgery to perform the hysterectomy, Bevins suffered a diminution of life style.

24. Tran, Franklin Square, and Medstar had a duty to provide, individually, and by and through its agents, servants, representatives, employees, and/or referrals to physicians and health care providers, competent medical care in accordance with accepted standards of medical, gynecological and surgical care. Tran negligently caused three vesicovaginal fistula during the surgery to perform the hysterectomy, negligently failed to repair same, and negligently failed to diagnose the three vesicovaginal fistula during several follow up visits to her office.

25. Tran, Franklin Square, and Medstar had a duty to perform the hysterectomy without causing injury to surrounding organs and had a duty to diagnose the injury and repair same.

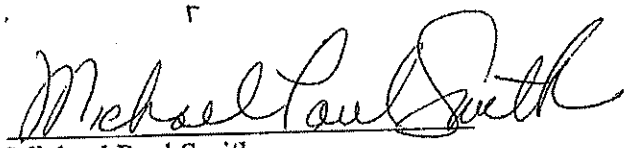
26. As a direct and proximate result of Tran, Franklin Square, and Medstar's breach of duty, Bevins has suffered permanent and temporary physical injuries, economic damages, mental anguish, loss of consortium, and other damages.

WHEREFORE, Plaintiff demands judgment for damages in the amount of $2 Million ($2,000,000) as compensation be entered against Tran, Franklin Square, and Medstar, jointly and severally.

Michael Paul Smith, Esquire
Bodie, Nagle, Dolina, Smith & Hobbs, PA
143 Main Street
Reisterstown, MD 21136
410-833-1221
Attorney for Plaintiff

PRAYER FOR JURY TRIAL

Plaintiff hereby prays that this matter be heard by a jury.



Michael Paul Smith

Case: 03-C-05-007420

CF-Civil Fili	80.00
Appearance Fee	10.00
MLSC	25.00
TOTAL	$115.00

COMMENT:
Bevins v. Iran et al

Receipt #20050013900
Cashier: DLB CCPACCX030
07/07/05 3:57PM

MedStar Health
Franklin Square Hospital Center
Baltimore, MD 21237

Name: Bevins, Cathy Location: 3C 375 2 Medical Record #: 213-70-4055

Date of Admission: 08/21/2002 **Date of Discharge:** 08/24/2002

Attending Physician: , M.D.

Referring Physician:

Dictated By: ARLENE EMMONS, M.D.

Chief Complaint: Scheduled surgery.

Present Illness and Past Medical History: This is a 43-year-old para 2-0-1-3 with a history of uterine fibroids. She reported her menses have actually become more irregular and heavier with severe dysmenorrhea. After discussion of risks, benefits and alternatives, an informed consent was obtained for a total abdominal hysterectomy.

The patient has an endometrial biopsy on 06/11/02 which was within normal limits. Her sonogram on 06/11/02 revealed a uterus that was 10 x 5.8 x 5.1 cm with multiple fibroids. She has an anterior fibroid that was 3.8 cm and fundal fibroid that measured 2.8 cm.

Past Medical History: (1) Neck fusion x 2. (2) C-section x 1. (3) Laparoscopic bilateral tubal ligation.

Physical Examination: Temperature was 97.2, pulse 90, respirations 18, blood pressure was 130/58 and 99% oxygen saturation on room air. Lungs: Clear to auscultation bilaterally. Cardiovascular: Regular rate and rhythm. Abdomen: Positive bowel sounds. Soft, nontender and nondistended. Extremities: No clubbing, cyanosis or edema.

Laboratory and Imaging Studies: Laboratories on admission: On 08/13/02, her white blood cell count was 6.1, hemoglobin 13.1, hematocrit 37.0 and platelets 234.

The patient is O+.

Hospital Course: The patient underwent an uncomplicated total abdominal hysterectomy secondary to symptomatic uterine fibroids.
Postoperatively, the patient was placed on morphine PCA pump for pain control, Cefotan for prophylactic antibiotics and then was maintained n.p.o. until the bowel function started returning.

On postoperative day #1, she was placed on a clear liquid diet. The patient complained of lightheadedness upon standing and was orthostatic by pulse. Her postoperative hemoglobin was obtained, and it was 9.2.

The patient, at that time, was given an IV bolus, and her hemoglobin was rechecked and was stable. The patient's discharge hemoglobin was 9.2.

The patient had slow return of bowel function and was advanced to a regular diet on postoperative day #3. She also developed a temperature of 100.2 on postoperative day #3 with no focal findings on exam. A contributing factor could have been secondary to the patient being catheterized several times due to postoperative urinary retention. The patient remained afebrile and was discharged home on postoperative day #3 with a Foley in place.

Procedures: Total abdominal hysterectomy.

Final Diagnoses:
1. Uterine fibroids.
2. History of cervical fusions.
3. Urinary retention.
4. History of cesarean section.

Condition on Discharge: Stable.

Discharge Medications:
1. Percocet 1-2 p.o. q.4-6h. p.r.n. pain.
2. Macrobid 1 b.i.d. while the Foley is in place.

Discharge Instructions:
1. The patient was instructed that she may resume her regular diet.
2. No driving for 3 weeks.
3. No tub baths for 3 weeks:
4. The patient was also instructed no douching, intercourse or lifting anything over 15 pounds until checkup.

Disposition: Home.

Follow-up: The patient is to see Dr. Tran in 1 week for staple removal and catheter removal.

HANH TRAN, M.D.

Dictated By: ARLENE EMMONS, M.D.

AE/sga

DD: 11/24/2002 9:37 A DT: 11/24/2002 11:59 A
314894
cc: ARLENE EMMONS, M.D.
HANH TRAN, M.D.
UNASSIGNED UNASSIGNED

MedStar Physician Partners

PROGRESS NOTE

Name: Bevins, Cathy

MRN / DOB: 2-16-59

DATE	NOTES
10-1-02	pt for followup
	urine dip - tr bld
	Repts ⊕ cultures last 2 days. urine cx from last
	visit still >100K proteus. will cont. c̄ bactrim bid x
	additional 7 days, then cont. prophylactic dose
	of ī tab qd x ī mth.
	cont. ditropan
	F/u [illegible]
10/29/02	Post op visit: Dipped pts urine. It was neg. and
	we are sending it out.
	Pt scheduled c̄ Dr Dowling (urology) on 11/12/02 for
	cystoscopy + fulguration of probable vesicovaginal fistula.
	Finished bactrim ~ 1wk ago. asymptomatic, will v urine cx
	to r/o infection.
	F/u p̄ surgery.

MR-006 (1/00) (F3F)

MedStar Physician Partners

PROGRESS NOTE

Name: Cathy Bevins

MRN / DOB: 2-16-59

DATE	NOTES
9/17/02	PT ~~ofebien~~ oestop:
	Pt for f/u. urine cx from 9/9/02 proteus resistant
	to macrobid but sensitive to bactrim
	Bladder control improving.
	Continue ditropan.
	F/u in 2wks.

MR-006 (1/00) (F3F)

Franklin Square Hospital Center
Franklin Square Driv
more, Maryland 2123
443-777-7000
MedStar Health

Outpatient Center
Progress Notes

Cathy Bevins
2-16-59
213-70-4055

Date	Prob. No.	Progress Notes	Drs. Orders
7/5/02		Pt. here for post-op surgery 7/21/02 [illegible]	
		BP - 122/63 Wgt - 168	
		Pt s/p TAH ~ 2 wks ago: Catheter removed ~ 1 wk ago and pt notes able to void regularly for ~ 3 days afterwards, then unable to hold urine	
		PVR today → 80cc.	
		probable urinary distention Foley placed, will maintain x 1 wk, then attempt voiding trials again	
		Macrobid 100mg qd for prophylaxis	
		Addendum	
		Will also start on ditropan XL 5mg to help c bladder control.	
		Ditropan XL 5mg #30 x 4R.	
		~~Dis~~ CVS 410-284-3530.	
9/9/02		Post op: The second day there was a lot of ~~trickl~~ trickling and burning	
		Pt ~~[illegible]~~ reports severe dysuria, hematuria:	
		u/a: ⊕nit / leuk / bld	
		Given severe UTI, will d/c Foley now & also to Bactrim DS bid x 5 days f/u cx + sensitivity.	
		Bladder training c void q 2hrs, ditropan & ↑ po hydration	

Diagnosis:

Signature ______________________
Attending or House Staff Physician

T-2612-7 Rev. 1/93

Franklin Square Drive
Baltimore, Maryland 2123
443-777-7000

Franklin Square Hospital Center
MedStar Health

BEVINS, Cathy
213-70-4055
02-16-59

Outpatient Center
Progress Notes

Date	Prob. No.	Progress Notes	Drs. Orders
6/18/02		u/s report reviewed c pt → bulky uterus sugg of fibroids c largest discrete fibroid anterior (3.0cm). EMB → secretory phase ø hyperplasia. Pt still c menorrhagia + severe dysmenorrhea. Surgical options d/w pt. Not TVH candidate given previous c/s + bulky uterus. Would do TAH, poss BSO. Pt to call back c decision on whether to proceed c surgical intervention. [signature]	
7/19/02		Preop: Weight: 107 BP 120/58	
		Pt here to discuss surgery. Surgical procedure + post operative discussed. For TAH 8/21/02 [signature]	
8/26/02		Pt. F/U from hysterectomy. Pt S/P hysterectomy on Wednesday 8/21 – D/c'ed home c foley 8/24 – here for postop staple removal. Staples removed incision site well healed steristrips applied. Foley leg bag placed. Will keep foley in for 2 more days. [signature]	
8/28/02		Pt here for catheter removal. Bladder filled c 180cc sterile water, pt voided s difficulty. F/u 5wks. [signature]	
Diagnosis:		Script for percocet 5/325 #40.	

Signature ______________________
Attending or House Staff Physician

T-2612-7 Rev. 1/93

ADVANCED RADIOLOGY
www.advancedradiology.com

O'Dea Medical Arts
7505 Osler Dr
Suite 406
Towson, MD 21204
(410) 580-2200
Fax: (410) 580-2227

HANH TRAN MD
1576 MERRITT BLVD
SUITE 3
BALTIMORE, MD 21222

Patient:	**BEVINS,CATHY A**
Soc. Sec. #:	**213-70-4055**
D.O.B.:	**02/16/1959**
Age:	**43**
Phone:	**(410)288-0669**
Account #:	**2299602**

10/11/2002: X-RAY INTRAVENOUS PYELOGRAPHY

CLINICAL INDICATION: Incontinence. Status post hysterectomy on 08/21/2002. Urinary tract infections.

Scout: No radiopaque urinary tract stones are identified.

IVP: The patient received 50 cc intravenous Isovue-300 with no adverse reaction. There are prompt bilateral nephrograms. The kidneys are symmetrical in size with smooth renal contours. There is symmetrical excretion into normal appearing collecting systems bilaterally. Both ureters follow normal course and caliber to the bladder. The bladder is unremarkable. There is a moderate post-void bladder residual. No vesicovaginal fistula is identified, but contrast in the bladder is somewhat dilute. If there is strong clinical suspicion for a vesicovaginal fistula, a cystogram would be recommended.

IMPRESSION:

1. Moderate post-void bladder residual.
2. Otherwise unremarkable intravenous pyelography.
3. No vesicovaginal fistula is identified. If there is strong clinical concern for a vesicovaginal fistula, then a cystogram would be recommended.

Bertan Ozgun MD

Bertan Ozgun, M.D.
ep

OCT 15 2002

[redacted]

MedStar Health
Franklin Square Hospital Center
Baltimore, MD 21237

Name: Bevins, Cathy J | Location: AMB | Medical Record #: 213-70-4055

Date of Operation/Procedure: 11/12/2002

Preoperative Diagnosis: Urinary incontinence, rule out vesicovaginal fistula

Postoperative Diagnosis: Vesicovaginal fistula

Procedure Performed: Cystoscopy, examination under anesthesia and fulguration of vesicovaginal fistula

Surgeon: WILLIAM DOWLING, M.D.

Assistant: None (WD)

Anesthetist: D. Botts, CRNA

Anesthesia: IV sedation

Indications for Procedure: 43 year old female is status post an abdominal hysterectomy. Shortly after that operation she developed complete urinary incontinence. She has been treated with anticholinergic medications with no improvement in her symptoms. The risks of the procedure were discussed in detail with the patient and she understands these risks, options to the therapy and elects to proceed. The patient was given 80 mg. of Gentamicin IV before the operation was begun.

Procedure: The patient was taken to the OR and IV sedation was administered. She was placed in the lithotomy position, prepped and draped in the usual sterile fashion. A speculum was placed in the vagina and near the vaginal apex was a small amount of clear fluid. Speculum was removed. #22 French rigid cystourethroscope was advanced into the bladder on direct vision. The urethra was normal. The bladder was inspected using both the #30 degree lens and #70 degree lens. No tumors were identified. Both of the ureteral orifices were normal. On the posterior wall of the bladder, there were two "pits". Each was suspicious for a vesicovaginal fistula. The pit on the right is about 7 mm. in size. The pit on the left is about 3 mm. in size. Both are within the confines of the ureteral orifices.

The bladder was emptied. The cystoscope was removed and #60 French Foley catheter was inserted to the bladder. Tampon was placed in the vagina. 200 cc. of sterile water colored with methylene blue were instilled into the bladder. The tampon was removed. The tip was found to be blue. With a speculum in place, a blue fluid could be seen in the vaginal apex. Therefore, having made the diagnosis of a vesicovaginal fistula, the Foley catheter was removed. #22 French cystoscope was replaced. The fistulae

[redacted]

were fulgurated using Bugbee electrode. A new #18 French Foley catheter was inserted. This was connected to gravity drainage and the patient was taken to the recovery room in stable condition.

I

WILLIAM DOWLING, M.D.

Dictated By:WILLIAM DOWLING, M.D.

WD/ksa

DD: 11/12/2002 1:36 P DT: 11/13/2002 11:19 A
cc: WILLIAM DOWLING, M.D.
THEODORE STEPHENS, M.D.

BEVINS, Kathy

Telephone Call
William T Dowling, M D , F A C S
11/13/02

Kathy Bevins had a cystoscopy with fulguration of a vesicovaginal fistula yesterday at Franklin Square Hospital. She called today complaining of bladder spasms and a slight amount of leakage of urine from the vagina. I have asked her to start Ditropan XL 5 mg q.d. She has this medication at home I suspect she is having bladder spasms which are resulting in some leakage from the vagina. Hopefully over time the bladder mucosa will reepithelialize and the fistula will heal She will follow-up with me as scheduled in two weeks for catheter removal

WTD:pa

WTD

BEVINS, Cathy (213-70-4055)
DOB: 02/16/59

Follow-up Note
William T Dowling, M D , F.A.C S
11/20/02

Cathy Bevins was seen today in follow-up. She was recently diagnosed with a vesicovaginal fistula. Eight days ago she had a cystoscopy with fulguration and catheter placement. She has developed severe bladder spasms. She continues to leak from the vagina and through the Foley catheter suggesting that the fulguration has not been successful

I have referred her to Dr. James Wright at Johns Hopkins Bayview for repair of her vesicovaginal fistula. Today's urinalysis is significant for 10 to 15 WBC per high power field. A few white blood cells are seen, rare bacteria.

WTD:pa

WTD

BRADY UROLOGICAL INSTITUTE
4940 Eastern Avenue
Baltimore, Maryland 21224

Name: Cathy Bevins JHB #: 1359112

Date: February 4, 2003

HISTORY:

Ms. Bevins is seen today for cystoscopy. She has a history of vesicovaginal fistula in the past which closed following cauterization. It has opened in the last few weeks and she presents today with continuous incontinence.

PROCEDURE NOTE:

A #17 French flexible scope was introduced into the bladder. There is a puckered erythematous area proximal to the trigone in the midline. The remainder of the interior of the bladder is normal in appearance and there is efflux from the bilateral ureteral orifices. Speculum exam is carried out and this shows a punctate opening at the vaginal cuff in the midline. There is associated fluid loss with a full bladder.

IMPRESSION AND PLAN:

Ms. Bevins is counseled as to vesicovaginal fistula repair. I told her that I thought it possible to repair this transvaginally. There is a potential for recurrence as well as the onset of urinary urgency. I discussed the nature of this closure including the possibility of an abdominal repair as well as the risks of abdominal surgery. We discussed the twenty-three hour hospital stay and the need for catheter drainage for a two week period postoperatively. The remainder of her questions were answered. Arrangements for surgery will be made.

E. James Wright, M.D.
Urology

EJW/CT/jsw
2/6/03

EXHIBIT
C

Johns Hopkins Bayview Medical Center

OPERATIVE REPORT

		History No:	1359112
Name:	Bevins, Cathy		
Attending Surgeon:	Wright,Edward	Service:	SUR
Assistant(s) :	Boyle,Karen		
Date of Operation:	02/05/2003	Document No:	45003000020

Title of Operation: Closre of vesicovaginal fistula; vaginal approach.

Indications for Surgery:

The patient is a 43-year-old woman with a vesicovaginal fistula following abdominal hysterectomy. She underwent cystoscopy which demonstrated a midline punctate abnormality proximal to the trigone. This was associated with fluid leakage per vagina. She is taken to the operating room today for definitive closure.

Preoperative Diagnosis: Vesicovaginal fistula.

Postoperative Diagnosis: Vesicovaginal fistula.

Anesthesia: General.

Specimen (Bacteriological, Pathological or Other):

None.

Prosthetic Device/Implant:

Surgeons Narrative:

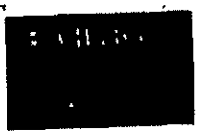
Estimated Blood Loss: 100 cc.

Drains: 16-French Foley catheter, Premarin vaginal pack.

Complications: None.

Disposition: Stable to recovery room.

Procedure: The patient was taken to the operating room where she was placed in the lithotomy position following successful induction of general anesthesia. She was prepped and draped in the normal sterile fashion. A perineal Omni



retractor was introduced and exposure of the vaginal cuff was undertaken. Cystoscopy was carried out with 30 and 70 degree lens. There was a crater-like area proximal to the trigone in the midline. This corresponded with 3 areas of leakage at the site of the vaginal cuff. An 035 Glidewire was introduced into each of these sites. Subsequent cystoscopy showed all 3 wires to enter the bladder through this excavated area. The 4-0 Vicryl stay sutures were placed along the vaginal cuff, and each of the fistulous tracts circumscribed with a #11 blade. The vaginal epithelium was elevated radially to reopen the vaginal cuff in its entirety. The area of scar was resected and discarded. With adequate mobilization of the vaginal epithelium, the bladder was reduced away from the vaginal cuff. A 5-0 Vicryl suture was used to close each of the fistulous tracts in 2 offsetting layers. The fistulous tracts themselves were not resected. With adequate closure, the bladder was filled and cystoscopy again carried out. There was no evidence of fluid leak on closure of the fistulae. The posterior aspect of the bladder base was reapproximated to the anterior aspect of the vaginal epithelium to separate the original fistulous tract from the planned vaginal closure. This was accomplished with 3-0 interrupted Vicryl suture. This effectively separated the suture lines once again. The bladder was finally inspected and the fistulous tract showed evidence of closure. There was no fluid leak through the base of the bladder following these maneuvers.

The vaginal epithelium was then reapproximated proximal to the fistulous tract in a modified Latzko technique. This vaginal cuff closure was completed with 3-0 interrupted Vicryl suture. Final cystoscopy showed efflux of indigo carmine from the bilateral ureteral orifices and excellent closure of the fistula. The open vaginal cuff and vagina were copiously irrigated and evacuated prior to closure. At the conclusion, the vagina retained adequate functional depth. A Premarin pack was placed into the vagina, and a 16-French Foley catheter introduced and set to straight drainage. The patient was returned to the supine position, awakened in the operating room, and taken to the recovery room in stable condition having tolerated the procedure well. At the conclusion of the procedure, sponge and needle counts were announced as correct. I was present and scrubbed for the entire procedure.

CC List:

Dr. Dowling; Maryland Urology Associates

DICTATED BY: WRIGHT, EDWARD J, M.D. /440 D: 02/05/2003 T: 02/06/2003

Provider WRIGHT, EDWARD 02/12/2003
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Note: This operative note provides information pertaining only to the patient's most recent hospitalization. A more detailed medical history is available in the medical record.