

MAN WHO BECAME SYMBOL OF OPPOSITION TO I-330
SETTLES MEDICAL MALPRACTICE CASE

Dennis "Rocky" Rockenbach became the symbol of what was wrong with Initiative 330. Rocky was featured in TV ads as well as print mailings. This ad was so effective that the pro I-330 campaign ran a rebuttal ad saying that Rocky would receive "millions of dollars" even if I-330 was in effect.

Although his case was still pending, Rocky voluntarily thrust himself into the "No on I-330" campaign.

His injury made him an excellent spokesperson for the "No on I-330" campaign. However, the factual background surrounding his claim represents a more compelling reason to hold medical care practitioners responsible for their actions.

In January, 2003, Rocky was developing hoarseness in his voice. This was a condition that had reoccurred due to the development of a papilloma on his vocal cords. A number of years before, Rocky had the papilloma surgically removed from his vocal cords. The ENT's handling his care recommended that in 2003 he should again have the papillomas removed from his vocal cords, but this time it should be done with a laser procedure which would reduce the risk that they would reoccur. He was scheduled for the laser surgery to be performed at St. Joseph Hospital in Bellingham. The surgery was to be performed by Dr. Joost Knops and the anesthesiologist involved was Dr. Kenneth Kloehn.

Rocky was administered general anesthesia by Dr. Kenneth Kloehn. In laser surgery procedures involving the throat, a special type of endotracheal tube is utilized by the anesthesiologist. The endotracheal tube has an inflatable cuff surrounding the tube. Once the intubation takes place the cuff is inflated by the insertion of blue saline. The inflated cuff provides a secure seal in the throat preventing anesthesia gases from entering into the surgical field.

The endotracheal tube comes with a package insert which warns the surgeon and anesthesiologist that if the cuff is perforated and blue liquid is seen during the surgery, the surgery must be stopped and a replacement endotracheal tube must be utilized. The package insert also notes that in a laser procedure a higher concentration of oxygen increases the risk of a surgical fire and that under no circumstances should more than 40% oxygen be administered to a patient.

In the 1990's as laser surgery became more prominent, St. Joseph Hospital began requiring that a laser safety nurse participate in all laser procedures. The nurse's primary function was to promote and address safety issues. The hospital also adopted a policy and procedure requiring a physician to be designated as a Laser Safety Officer and require annual training of all medical care practitioners involved in laser procedures. When the program was initiated in the 1990's a Laser Safety Officer was designated. Unfortunately, the policy, despite being adopted in writing, was ignored by the hospital. No replacement Laser Safety Officer was designated. In addition, the training of the laser

safety nurses was basically non-existent. At the time of Mr. Rockenbach's laser surgery in January of 2003, there was no Laser Safety Officer. In addition, the surgeon who performed the laser procedure, Dr. Joost Knops, despite being qualified, did not have privileges to perform laser surgery at St. Joseph Hospital.

Mr. Rockenbach was intubated, the protective cuff was inflated, and the anesthesiologist, contrary to national standards, began administering 100% oxygen. The surgeon, Dr. Joost Knops, began the laser surgery to remove the papillomas from the vocal cords. The laser apparently perforated the endotracheal cuff and blue liquid entered the surgical field. The surgeon, Dr. Knops, identified the blue liquid and advised the laser safety nurse to turn off the laser. Dr. Knops and the anesthesiologist looked for a replacement endotracheal tube in the operating room. No replacement tube was present. A nurse was sent from the operating room to obtain a replacement endotracheal tube.

The surgeon and anesthesiologist discussed the possibility of proceeding with the surgery before a replacement tube was obtained. The hospital's laser safety nurse did not participate in the discussions. The two physicians decided to proceed with the laser surgery because they were almost finished. Again, the laser safety nurse said nothing.

The laser procedure was restarted. The nurse returned with the replacement endotracheal tube. Despite this fact, the two physicians continued with the surgery rather than replace the tube.

The laser ignited a cotton string in the surgical field. The 100% oxygen being administered to Rocky fueled the surgical fire in his throat. The 100% oxygen created a blow torch type effect, burning for approximately four seconds. The anesthesiologist turned off the oxygen and the surgeon doused the fire with a bowl of saline solution. Mr. Rockenbach was transferred to the ICU with severe throat and vocal cord injuries caused by the fire.

Mr. Rockenbach's care was eventually transferred to UCLA Medical Center which has expertise in severe throat injuries. He has had more than 20 surgical procedures performed. He requires a permanent tracheostomy. His voice is limited to a whisper since his vocal cords were burned in the fire. The tracheostomy site contains a "T" tube which extends outside of this throat. This "T" tube needs to be surgically replaced at UCLA two times per year. This is a permanent condition.

Mr. Rockenbach, who pre-incident was an extremely strong, physical, outdoor person, is relegated to a sedentary life. He needs to be hooked up to a misting machine multiple times per day to humidify his lungs.

The case was scheduled for trial in Whatcom County February 28, 2006. Immediately before trial, the two physicians offered their policy limits of insurance of \$1 Million each. The hospital offered \$3 Million before the start of trial, for a total offer of \$5 Million.

The first day of trial when motions in limine were being argued, the three defendants, in an attempt to prevent the egregious facts from being presented to the jury, all admitted liability and dropped any

cross claims for contribution. In response to the admission of liability and dismissal of cross claims, plaintiff agreed to settle with the two physicians for their policy limits of insurance and advised that Mr. Rockenbach was going to proceed against the hospital only based upon the hospital's admission of liability and dismissal of cross claims.

The next day the trial was scheduled to reconvene at 1:30 p.m. At that time the trial judge was going to rule on whether or not the hospital would be allowed to resurrect a claim for contribution or offset against the physicians or if the claims against those physicians were dismissed. The hospital was given a "take it or leave it" offer of settlement that would expire when the trial was to recommence at 1:30 p.m. The hospital accepted the "take it or leave it" offer to settle for a payment of \$5 Million. The entire case settled the following day at 1:30 p.m. for a global settlement of \$7 Million.

Mr. Rockenbach had no claim for loss of income. Had I-330 passed his claim would have been reduced to past and future medical bills plus a \$350,000 cap on general damages.

Plaintiff was represented by Paul N. Luvera and Ralph Brindley of Luvera, Barnett, Brindley, Beninger & Cunningham.

Defendants were capably represented. The hospital's attorneys were Mr. John Graffe and Mr. Jeff Burnham of Johnson, Graffe, Keay, Moniz & Wick.. Dr. Knops was represented by Mr. Jim Martin of Hoffman, Hart & Wagner. Dr. Kloehn was represented by Ms. Amy Forbis of Bennett, Bigelow & Leedom.