STATE OF WISCONSIN CIRCUIT COURT MILWAUKEE COUNTY

NESTOR VEGA
2367 S. 15th Milwaukee, Wisconsin 53215,

Plaintiff,

v.

FROEDTERT MEMORIAL LUTHERAN HOSPITAL, INC.,
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

DOCKET NO:

THE MEDICAL COLLEGE OF WISCONSIN, INC.
8701 Watertown Plank Rd.
Milwaukee, WI 53226

CHAD BECK, MD
c/o Froedtert Mem. Lutheran Hospital, Inc.
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

MARC-ANTOINE TREMBLAY, MD
c/o Froedtert Mem. Lutheran Hospital, Inc.
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

AUSTIN MIDDLETON, MD
c/o Froedtert Mem. Lutheran Hospital, Inc.
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

TAUREAN BAYNARD, MD
c/o Froedtert Mem. Lutheran Hospital, Inc.
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

JOHN S. SYMANKI, MD
c/o Froedtert Mem. Lutheran Hospital, Inc.
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

MONICA C. RYAN, PA-C
c/o Froedtert Mem. Lutheran Hospital, Inc.
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

INJURED PATIENTS AND FAMILIES COMPENSATION FUND,
125 South Webster Street,
Madison, WI 53702

Defendants.

SUMMONS

THE STATE OF WISCONSIN

To Each Person Named Above as a Defendant:

You are hereby notified that the Plaintiff named above has filed a lawsuit or other legal action against you. The complaint, which is attached, states the nature and basis of the legal action. Within forty-five (45) days of receiving this Summons, you must respond with a written Answer, as that term is used in Chapter 802 of the Wisconsin Statutes, to the Complaint. The Court may reject or disregard an Answer that does not follow the requirements of the statutes. The Answer must be sent or delivered to the Court, whose address is Milwaukee County Clerk of Circuit Court, 901 N 9th St, Milwaukee, WI 53233, and to The LaMarr Firm, PLLC, Plaintiff's attorney, whose address is 5718 Westheimer Rd., Suite 1000, Houston, TX 77057. You may have an attorney help or represent you.

If you do not provide a proper Answer within forty-five (45) days, the Court may grant Judgment against you for the award of money or other legal action requested in the Complaint,

and you may lose your right to object to anything that is or may be incorrect in the Complaint. A Judgment may be enforced as provided by law. A Judgment awarding money may become a lien against any real estate you own now or in the future, and may also be enforced by garnishment or seizure of property.

Dated this 31st day of August 2023.

The LaMarr Firm, PLLC

By: /s/ B'Ivory LaMarr
B'Ivory LaMarr, Bar No. 1122469
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Houston, TX 77057
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Attorney for Plaintiff

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125 South Webster Street,
Madison, WI 53702

Defendants.

COMPLAINT AND JURY DEMAND

Comes now the Plaintiff, Nestor Vega, in the above-styled matter and represents and avers the following:

IDENTIFICATION OF PARTIES, JURISDICTION, AND VENUE

1. Plaintiff, NESTOR VEGA (hereinafter "VEGA"), is a citizen of the State of Wisconsin and lives at 2367 S. 15th Milwaukee, Wisconsin 53215.
2. The Injured Patients and Families Compensation Fund (hereinafter "IPFCF") is a risk sharing pool established under *Wis. Stat. 655.27 (5)*. Its principal place of business is at 125 South Webster Street, Madison, Wisconsin 53702.
3. Froedtert Memorial Lutheran Hospital, Inc. (hereinafter "FROEDTERT"), The Medical College of Wisconsin, Inc. (hereinafter "MCW"), Chad Beck, MD (hereinafter "DR. BECK"), Marc-Antoine Tremblay, MD (hereinafter "DR. TREMBLAY"), Austin Middleton, MD (hereinafter "DR. MIDDLETON"), John S. Symanki, MD (hereinafter DR. SYMANKI), Monica C. Ryan, PA-C (hereinafter RYAN) and TAUREAN BAYNARD,

MD (hereinafter DR. BAYNARD), the resident doctor, were all health care providers and employees permanently practicing or operating in Wisconsin, all within the meaning of and under *Chapter 655* of Wisconsin Statutes. The IPFCF provides occurrence coverage for health care providers permanently practicing or operating under Chapter 655, Wisconsin Statutes, and for employees of health care providers, and thus the IPFCF is directly liable to Mr. VEGA for his damages as alleged below and is a proper party to this action.

4. FROEDTERT is a Wisconsin corporation and its registered agent is Amy Marquardt. Its principal place of business is located at 9200 West Wisconsin Avenue, Milwaukee, Wisconsin 53226. FROEDTERT provides facilities, services, and care to patients.
5. The MCW is a non-stock Wisconsin corporation, with a principal place of business located at 8701 Watertown Plank Road, Milwaukee, Wisconsin. It is licensed to provide health care services in Wisconsin. Its registered agent is John T. Newsome, Esq., 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.
6. Defendants DR. BECK, DR. TREMBLAY and DR. MIDDLETON are surgeons and physicians at FROEDTERT with their business address located at 9200 West Wisconsin Avenue, Milwaukee, Wisconsin 53266.
7. Defendant, JOHN S. SYMANKI, MD, is a licensed radiologist at FROEDTERT with business address located at 9200 West Wisconsin Avenue, Milwaukee, Wisconsin 53266.
8. Defendant, RYAN, is a physician assistant at FROEDTERT with business address located at 9200 West Wisconsin Avenue, Milwaukee, Wisconsin 53266.
9. Defendant, DR. TAUREAN BAYNARD, is a resident at FROEDTERT with business address located at 9200 West Wisconsin Avenue, Milwaukee, Wisconsin 53266.

10. The incident causing this action occurred on or about September 2, 2020, and sometime thereafter in Milwaukee, Milwaukee County, Wisconsin.
11. Jurisdiction of this court is proper pursuant to *Wis. Stat. 801.50 (2)(a)* as the claims asserted herein arose in Milwaukee County.
12. The matters asserted herein are tort claims in excess of $5,000.00.

STATEMENT OF RELEVANT FACTS

13. Nestor Vega ("VEGA") was involved in a motor vehicle collision on July 24, 2020.
14. On that same day, VEGA presented to FROEDTERT and the evaluation revealed a closed right pilon fracture. He was put into a splint with provisional reduction.
15. On July 25, 2020, VEGA underwent closed reduction and an external fixator of the right distal tibia pilon fracture.
16. On August 13, 2020, VEGA presented to FROEDTERT for a follow-up examination, wound check, pin care, and dressing changes in cast room. At such time, Vega complained of a substantial persistent swelling to his ankle and foot since that resulted from his operation. Such pain continued despite elevation of his leg and ice application.
17. On September 2, 2020, VEGA underwent the removal of the right ankle external fixator and open reduction, internal fixation of right pilon fracture. The surgery was performed by DR. BECK, DR. TREMBLAY and DR. MIDDLETON. The procedure was videotaped and documented accordingly.

18. VEGA's wound was thoroughly rinsed with copious amounts of sterile saline. A 10-French drain[1] was placed and the wound was closed in a layered fashion. VEGA was then placed in soft dressings as well as a short leg splint.

19. During the attempt to remove the surgical drain from VEGA by DR. BECK, DR. TREMBLAY, and DR. MIDDLETON, a loud noise erupted which was the result of a piece of the drain fragment breaking off into the surgical area upon which the defendants were operating.

20. VEGA heard the noise and observed the subsequent attempts by the defendants to find and remove the drain fragment from inside his leg, to no avail. VEGA also witnessed other FROEDTERT medical staff enter his room to inquire as to the loud noise, and was advised by the defendants that a drain fragment had broken off inside VEGA'S ankle.

21. DR. BECK, RYAN, DR. BAYNARD, DR. TREMBLAY, and DR. MIDDLETON were present for the entirety of this procedure.

22. On September 3, 2020, DR. BAYNARD attended to VEGA, during which VEGA communicated experiencing intense pain, stating, **"Something isn't right, it feels like something is pulling"** in addition to expressing his concern of infection resulting from the retained fragment.

23. VEGA expressed his concern of infection resulting from the retained fragment to each member of FROEDTERT medical staff he came in contact with but such concerns were dismissed without any reasonable justification. VEGA further pleaded for an X-ray to be taken but his continued pleas for an X-ray were denied.

[1] *(See Exhibit A attached hereto and incorporated herein by reference)*

24. Despite VEGA's insistence to speak to his surgeon, DR. BECK refused to come back into VEGA's room to address his concerns.

25. Above VEGA's legitimate concerns, FROEDTERT medical staff expressed their intent to immediately discharge VEGA despite his continued pleas for assistance, requests for X-rays, communication from his surgeon, and his maintained concern of the foreign object still being left inside him.

26. While wrapping VEGA's leg with bandages for discharge, DR. BAYNARD reassured VEGA that there was nothing left inside his leg. DR. BAYNARD further assured VEGA that even if the fragment was left, that it was "sterile" and would not cause an infection.

27. On September 3, 2020, VEGA was discharged after being provided with educational materials and discharge medications upon DR. BECK's instruction.

28. Despite having knowledge of the retained fragment, neither DR. BECK, nor any other of the named defendants promptly performed or scheduled VEGA for removal of the fragment from the drain.

29. Despite clear evidence involving the challenges in the removal of the surgical drain from VEGA, and the retained fragment thereof, according to VEGA's medical records, DR. BECK indicated **"NONE"** in response to whether there were complications resulting from said procedure.

30. DR. BECK and all other defendants failed to make any notation, whatsoever, of the complications and challenges experienced in removing the drain, the loud sound resulting from the break of the drain, and the known retention of the drain fragment inside VEGA.

31. On September 14, 2020, the defendant, DR. SYMANKI, a licensed radiologist, conducted an X-ray on VEGA as part of their post-operative care and follow-up visit at the Ortho Office in FROEDTERT. The findings were reviewed by DR. BECK and RYAN.
32. The defendants were responsible for properly reviewing, interpreting, and communicating the findings of the X-ray to the medical team.
33. Subsequent analysis of the X-ray revealed the presence of a linear foreign body or object that projected over the anterior (front) of the ankle indicating that it is an artifact or an object that's not part of the patient's anatomy, which was either overlooked, misinterpreted, or not adequately communicated to the medical team by the defendant.
34. During this time, DR. BECK and RYAN personally reviewed the findings of the X-ray and continually denied the prescence of any foreign objects in VEGA's body.
35. As a consequence, VEGA's condition continued to worsen, and he found himself in constant and grueling pain. The pain was so severe that it became unbearable for VEGA to carry out even the simplest daily activities. Every movement was accompanied by intense agony, and his ability to sleep, eat, and function normally was severely impaired.
36. The medical interventions provided were not effective in alleviating his suffering, and his quality of life was significantly impacted due to the retained fragment.
37. On November 9, 2020, a follow-up x-ray imaging was performed on VEGA. This exam was ordered by DR. BECK. The findings were further reviewed by RYAN under DR. BECK's supervision and it suggested that the ankle mortise was partially obscured by hardware and that a surgical material reflecting off the surgical site was visible in the imaging which represents a fragment of a drain. The same record was acknowledged by DR. BECK.

38. Despite the second x-ray confirming the existence of a foreign object, and VEGA's continued concern for infection, the retained fragment was not removed.

39. VEGA complained numerous times to both RYAN, DR. BECK, and other FROEDERT medical staff on each follow up visit, of his concerns and observation of the growing infection in his leg that he believed was a direct result of a foreign object being retained. Each time both RYAN, DR. BECK, and FROEDTERT medical staff dismissed such concerns and assured VEGA that nothing was wrong.

40. After almost 3.5 months of the foreign object residing inside VEGA's leg, VEGA presented to FROEDTERT's Emergency Department on December 13, 2020, for postoperative wound infection of his right leg, specifically, on the right distal tibia surgical site. The pain at his surgical site had worsened due to the infection and had started to display a reddish hue. The swelling and pain had increased and became unbearable. Intraoperative cultures were obtained showing bacterial growth, and VEGA was monitored for an infectious disease.

41. Surgical intervention was discussed with VEGA and was performed on December 15, 2020 by DR. BECK, Dr. Derek Parshall and Dr. Jonathan Bacos. The surgeons identified the segment of the retained drain upon its removal.

42. After the complete removal of the fragmented drain VEGA was cleared by therapy for discharge/transfer. VEGA was discharged on December 18, 2020.

43. After a short period of time following his discharge, VEGA began to experience a series of severe complications on his right ankle as a result of the Defendants' flagrant negligence and failure to properly treat and timely remove the drain fragments in his right ankle.

44. On March 1, 2021, VEGA presented to FROEDTERT for an incision or wound complication. VEGA was referred to Dr. Jill Martin for a surgery for the persistent wound along the anterior aspect of his right ankle.

45. VEGA reported that he was frustrated with the prolonged series of surgeries and hospitalizations due to his leg fracture and infection. VEGA expressed that his anxiety and depression had intensified as a result of a lack of progress even after undergoing multiple surgical procedures.

46. VEGA presented to Tenderness Health Care on March 8, 2022 for his depression and reported that he has been interested in receiving skin graft but he is unable to do so due to conflicts with his medications. VEGA further complained of increasing bilateral leg pain and aggravation with standing and walking.

47. As a result of this incident, VEGA is still treating the permanent aftermath of his infections, physical disfigurement, and continues to suffer from an inability to properly walk, exercise, prolonged pain and suffering, nerve pain, emotional distress and anxiety, loss of enjoyment of life, and past and future income loss.

COUNT I – MEDICAL MALPRACTICE AGAINST FROEDTERT MEMORIAL LUTHERAN HOSPITAL, INC., MEDICAL COLLEGE OF WISCONSIN, INC., DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD.

48. Plaintiff hereby incorporates all preceding paragraphs as though fully set forth herein.

49. FROEDTERT and MCW, through its agents and employees, had a legal obligation under the common law of Wisconsin and the laws of the State of Wisconsin to provide skillful, prudent, and diligent care, treatment, advice, and observation to VEGA. This duty required

FROEDTERT and MCW to adhere to the community's standard of care or the standard expected of a reasonably prudent medical hospital facing comparable conditions and circumstances.

50. DR. BECK, DR. TREMBLAY, DR. MIDDLETON, AND DR. BAYNARD were employees of FROEDTERT and MCW. As such, FROEDTERT and MCW bears vicarious liability for the negligent conduct of its employees. Throughout the relevant period, DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD were acting within the scope of their employment with FROEDTERT and MCW.

51. DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD, were the individuals directly responsible for providing medical treatment, assistance and care for the injuries sustained by VEGA. Defendants were employees of FROEDTERT and MCW who were under its exclusive control for their acts and omissions in relation to the incident.

52. During all relevant times, the defendants had a solemn responsibility towards the hospital's patients, ensuring strict adherence to the standard and duty of care without exception. Furthermore, it was incumbent upon them to exercise utmost caution and diligence in the post-operative care of their patients, taking proactive measures to prevent any potential complications.

53. Accordingly, a "special relationship" existed between VEGA and the defendants. By undertaking the decision to provide assistance, conduct surgery and treatment, and actively engage in caregiving, they willingly accepted the responsibility and liability for any injuries arising from negligence during the provision of care. Consequently, they must also be held

accountable for any injuries that may have been caused as a direct result of their care and actions.

54. Pursuant to *Wis. Stat. 893.55*, the defendants, FROEDTERT, MCW, DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD, are liable for medical malpractice that they committed when a foreign object, which has no therapeutic or diagnostic purpose or effect, was left in a patient's body within the course and scope of their engagement with and treatment of the plaintiff.

55. Furthermore, FROEDTERT, MCW, DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD, possessed full awareness of the potential harm that could arise from neglecting to remove the fragment of the drain from VEGA's body. Their knowledge and understanding of the risks and consequences associated with such negligence were evident.

56. Despite this awareness, as VEGA's surgeons, physicians, and nurses, neglected to take the necessary and appropriate actions to address the situation. This failure to act and provide the required medical intervention has not only resulted in the continued presence of the fragment but has also exacerbated the injuries and harm suffered by VEGA.

57. Despite the Defendants' awareness of the remaining fragment of the drain, they failed to promptly perform the necessary surgery to remove it.

58. Further, despite a FROEDTERT nurse[2] having complete awareness of the fragment lodged inside VEGA and the potential risks it posed, refrained from reporting the incident to hospital management or making any medical notes thereof.

[2] Believed to be Sara Cross, RN

59. This decision persisted even after DR. BECK failed to take the necessary steps to remove the fragment, which would have prevented VEGA's condition from worsening and potentially leading to severe complications.

60. DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD breached their duty to provide necessary and appropriate medical treatment and care to VEGA, resulting in medical malpractice. The breach occurred in one or more of the following ways:

    a. Breaching the standard of care to the extent that as the attending surgeons, resident, and nurse, they knew or should have known while they were present for the entirety of the September 2, 2020 surgical procedure, whether the right ankle external fixator and open reduction, internal fixation of right pilon fracture was completely removed, and the 10-French drain was properly placed.

    b. Breaching the standard of care to the extent that upon the discharge of VEGA after his September 2, 2020 surgical procedure, they should have made further evaluation on the condition of VEGA and of his surgical site. The defendants further failed to order an x-ray of the retained fragment on September 2, 2020 and prior to VEGA's discharge.

    c. Deviating from the standard of care to the extent that upon knowledge or reasonable knowledge of the retained fragment in VEGA's surgical site, they should have explored removing the retained fragment immediately.

    d. Failing to consider immediate removal of the retained fragment of the drain at the surgical site, despite knowing that it would lead to a surgical site infection requiring another surgery.

e. Deviating from the standard of care. They should have performed the needed procedures and treatment such as: antibiotic management, incision and drainage of the surgical site and revision surgery for removal of the drain fragment from the surgical site and hardware.

f. Breaching the standard of care to such an extent, DR. BECK prematurely discharged VEGA without implementing the necessary medical safeguards and procedures.

61. In addition, FROEDTERT and MCW breached the duty owed to VEGA to provide appropriate medical care and surgical procedures. The breach occurred in one or more of the following ways:

a. Failing to recognize and/or address instances of careless medical conduct, reckless care, and treatment by the doctors in the operating room, which resulted in injuries to VEGA.

b. Failing to establish policies and procedures for effective communication and reporting between doctors and medical professionals regarding the post-operative state or condition of patients.

c. Failing to ensure compliance with the standard of care, procedures, and policies during and after the operation.

d. Failing to recommend and emphasize the necessity of a subsequent operation to remove any retained fragments in the surgical site while VEGA was still within the hospital premises.

62. The Plaintiff placed his trust and reliance on FROEDTERT, MCW, DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD, with the expectation that they would provide care and services of a standard consistent with ordinary care and prudence.

63. FROEDTERT, MCW, DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD had knowledge of the violation, specifically regarding the retained fragments, and acquiesced or failed to take appropriate action.

64. FROEDTERT and MCW are also deemed liable to VEGA under the doctrine of apparent authority for the medical malpractice exhibited by DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD.

65. The Defendants' conduct were the proximate cause of the occurrence and damages sustained by the VEGA.

COUNT II – GROSS NEGLIGENCE AGAINST DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD

66. Plaintiff hereby incorporates all preceding paragraphs as though fully set forth herein.

67. DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD owed a duty to VEGA and the breach occurred in one or more of the following ways:

    a. Breaching the standard of care to the extent that as the attending surgeons, resident, and nurse, they knew or should have known while they were present for the entirety of the September 2, 2020 surgical procedure, whether the right ankle external

fixator and open reduction, internal fixation of right pilon fracture was completely removed, and the 10-French drain was properly placed.

b. Breaching the standard of care to the extent that upon the discharge of VEGA after his September 2, 2020 surgical procedure, they should have made further evaluation on the condition of VEGA and of his surgical site.

c. Deviating from the standard of care to the extent that upon knowledge or reasonable knowledge of the retained fragment in VEGA's surgical site, they should have explored removing the retained fragment immediately.

d. Failing to consider immediate removal of the retained fragment of the drain at the surgical site, despite knowing that it would lead to a surgical site infection requiring another surgery.

e. Deviating from the standard of care. They should have performed the needed procedures and treatment such as: antibiotic management, incision and drainage of the surgical site and revision surgery for removal of the drain fragment from the surgical site and hardware.

f. Breaching the standard of care to such an extent, DR. BECK prematurely discharged VEGA without implementing the necessary medical safeguards and procedures.

68. DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD's conduct was a proximate cause of the occurrence and damages sustained by VEGA.

COUNT III- MEDICAL NEGLIGENCE AGAINST DR. SYMANKI, MONICA C. RYAN AND FROEDTERT MEMORIAL LUTHERAN HOSPITAL, INC.

69. Plaintiff hereby incorporates all preceding paragraphs as though fully set forth herein.

70. Defendants DR. SYMANKI and MONICA are a licensed radiologist and physician assistant, respectively, practicing at FROEDTERT.

71. The defendants owed a duty of care to the plaintiff to properly review, interpret, and communicate the findings of the X-ray performed on VEGA.

72. The defendants breached that duty of care by either failing to identify the fragment of the surgical drain or by failing to adequately communicate its presence to the medical team, and/or escalate due to the omission to act by Dr. Beck, and document the extent of their knowledge in the Vega's medical and progress notes. As a result, DR. SYMANKI and RYAN are liable to the plaintiff and accountable for the damages outlined below, which stem from their breach of professional duties. These violations include, but are not limited to the following negligent acts and/or omissions:

    a. Failure to exercise the expected level of care and skill in reviewing and interpreting the X-ray, which led to the missed fragment of the surgical drain.
    b. Failure to promptly and clearly communicate significant or abnormal findings from the X-ray to the relevant medical team.
    c. Failure to identify the presence of the surgical drain fragment which delayed necessary medical intervention.
    d. Failure to communicate to the patient about the presence of the retained fragment.
    e. Failure to perform up to the established professional standards in their respective fields.

73. Following VEGA's surgery at FROEDTERT, an unidentified nurse[3] followed up with VEGA. During this interaction, VEGA expressed his concerns and complaints about the surgical procedure and the increased pain he was experiencing. Unfortunately, the nurse did not adequately document his complaints and, instead, reassured VEGA that the fragment was not present within his body.

74. As a direct and proximate result of the defendants' negligence, Vega suffered severe and permanent injuries, emotional distress, multiple surgeries, medical expenses, loss of earning capacity, and other damages.

COUNT IV – MEDICAL BATTERY AGAINST DR. BECK, DR. TREMBLAY, DR. MIDDLETON AND DR. BAYNARD

75. Plaintiff hereby incorporates all preceding paragraphs as though fully set forth herein.

76. The Defendants, DR. BECK, DR. TREMBLAY, DR. MIDDLETON, and DR. BAYNARD, were the individuals directly responsible for providing medical assistance and care for the injuries sustained by VEGA.

77. VEGA had provided consent for the operation performed by the defendants. However, during the course of the operation, there was a significant deviation from the procedure outlined in the granted consent.

78. Despite the expectation and intention for the complete removal of the 10-French drain from VEGA's surgical site, they encountered difficulties during the procedure, leading to fragmentation and the inability to remove it entirely.

[3] Believed to be Sara Cross, RN

Although the foreign object was present, the Defendants failed to fulfill this obligation, even though it was anticipated that the drain would be completely removed. This deviation from the anticipated course of action resulted in the retention of the drain fragment at the surgical site, highlighting a significant deviation from the established procedure; the defendants were aware that this would lead to harmful and objectionable consequences for VEGA.

79. Furthermore, the Defendants were aware of the potential risks and complications associated with the retention of surgical equipment fragments in the body. Despite this knowledge, VEGA was not properly informed or asked whether or not he preferred to retain or remove the fragment. The defendants failed to seek VEGA's consent or provide him with the necessary information to make an informed decision about the retention or removal of the fragment.

80. While wrapping VEGA's leg with bandages, DR. BAYNARD answered VEGA's questions and reassured him that there was nothing left inside his leg and assured VEGA that even if it was, the fragment was sterile and would not result in infection.

81. DR. BAYNARD was fully cognizant of the fragment left inside VEGA's leg, deliberately concealed this information, and engaged in deceptive practices by falsely reassuring VEGA that he was safe and there was no cause for concern.

82. The acts of the defendants indicate that they committed medical battery against VEGA by leaving the fragment of the drain inside his body. Despite being aware of the risks associated with the presence of the fragment, the defendants purportedly neglected to remove it, thereby potentially causing harm and exacerbating the damages suffered by VEGA.

83. The conduct of the Defendants was the proximate cause of the occurrence and damages sustained by VEGA.

COUNT V - FRAUDULENT MISREPRESENTATION AGAINST DR. BECK, DR. BAYNARD AND FROEDTERT MEMORIAL LUTHERAN HOSPITAL, INC.

84. Plaintiff hereby incorporates all preceding paragraphs as though fully set forth herein.

85. DR. BECK, is the attending surgeon and physician directly responsible for providing medical assistance and care for the injuries sustained by VEGA.

86. In a position of trust and confidence, DR. BECK conveyed that the surgery conducted on September 2, 2020, transpired smoothly and was devoid of any complications. Specifically, Dr. Beck, despite clear evidence involving the challenges in the removal of the surgical drain from Vega, and the fragment retention thereof, indicated **"NONE"** in Vega's medical records when asked about complications resulting from said procedure.

87. Moreover, during the post-operative follow-up examination on September 14, 2020, Dr. Beck reiterated the absence of any issues from the surgery and failed to communicate his knowledge of the retained fragment at such time. Dr. Beck maintained that, despite experiencing pain in his lower extremity post-surgery, VEGA was progressing well overall.

88. Despite the undisputed fact that a fragmented surgical drain was left inside the body of VEGA, DR. BECK intentionally denied and assured VEGA that he was doing well and assured VEGA that his concern of infection was not valid. This intentional action, which concealed a critical medical issue, not only breached the trust placed in medical

professionals but also misrepresented the true state of VEGA's health, resulting in the endangerment of both VEGA'S well-being and reliability of medical information communicated.

89. DR. BAYNARD, in a position of trust and confidence, knowingly withheld crucial information from the patient regarding the presence of the drain fragment inside the body. Additionally, he provided false reassurance to the plaintiff when questioned about his condition, misleading VEGA into believing that there was not a threat to VEGA'S well-being and that there was no need to be alarmed about any retained fragment(s).

90. During the bandaging process and while preparing VEGA for discharge, DR. BAYNARD addressed the concern about a small fragment of the drain possibly breaking inside. When asked, ***"so you don't think... that little thing broke in there, man?"*** by VEGA, DR. BAYNARD responded reassuringly, saying, ***"I don't think so. Even if it did, it should be sterile, and its small enough of a fragment, so it shouldn't cause any issues like an infection or anything."*** The same is not supported by any reliable medical methodology and was is reasonably construed to be an effort to conceal DR. BECK'S omission to act.

91. Furthermore, during the course of VEGA's medical treatment at FROEDTERT, an interaction took place with an unidentified nurse,[4] from the hospital. In this encounter, the nurse explicitly reassured VEGA that the piece of fragment in question was not present within his body. When VEGA desperately insisted that the piece remained, said nurse

[4] Believed to be Sara Cross, RN

responded several times “NO” and falsely represented to VEGA that DR. BECK checked the drain and that the tip of the drain remained intact.

92. Such actions resulted in acts to misrepresent and withhold the truth about the retained fragment and was an intentional misrepresentation of VEGA's medical status. Despite possessing knowledge of the presence of the fragment, the defendants chose to deceive and provide false information, thereby betraying the trust placed in them as medical professionals.

93. DR. BECK, DR. BAYNARD, and FROEDTERT’s culpability goes beyond mere negligence and constitutes fraud. As doctors performing their professional duties and responsibilities, their actions involve fraudulent misrepresentations to the plaintiff, to whom they owe the duty of disclosing the truth. This is particularly evident in their deliberate choice to not remove the fragments of the drain from the plaintiff's body, despite being aware of the potential complications it can cause based on the treatments and examinations they ordered and acknowledged.

94. The defendants were fully cognizant of the potential risks and complications that could arise from the non-removal of the fragments in VEGA's body.

95. Despite possessing this knowledge, the defendants failed to disclose the information and adequately explain to the plaintiff the potential risks and complications associated with retaining the fragments in his body. Due to this, the plaintiff was denied the opportunity to make informed decisions about his health and well-being, leading to potential harm and exacerbation of his condition.

96. Furthermore, DR. BAYNARD callously discharged VEGA, leading VEGA to believe, in good faith, that everything was fine, without making any effort to suggest a treatment or procedure for the removal of the fragment. This callous act not only deprived VEGA of necessary medical attention but also left him unaware of the potential risks and complications associated with the retained fragment, exacerbating his condition and causing additional distress.

97. This fraudulent misrepresentation aggravated the plaintiff's injury.

COUNT VI - VIOLATION OF FIDUCIARY DUTY AGAINST DR. BECK

98. Plaintiff hereby incorporates all preceding paragraphs as though fully set forth herein.

99. The defendant, DR. BECK, is directly responsible for providing medical treatment, assistance and care for the injuries sustained by VEGA. And has duties that go beyond the duty of care imposed by a negligence standard that requires him to treat his patient as well as he would want to be treated himself.

100. Pursuant to *Wis. Stat. 893.57*, the Defendant, DR. BECK, is liable for intentional torts, events, acts, and/or omissions that he committed in bad faith, deceit, or with knowledge of the lack of a reasonable basis for the conduct or a reckless disregard of a reasonable basis within the course of his engagement and treatment of the Plaintiff.

101. As a result, Mr. Beck is liable to the plaintiff and accountable for the damages outlined below, which stem from his breach of fiduciary duties. These violations include, but are not limited to, the following negligent acts and/or omissions:

    a. Breach of duty to the plaintiff by failing to recommend and emphasize the necessity of a subsequent operation to remove the fragments of the drain left in the surgical site while Vega was still within the hospital premises.
    b. Breach of duty to comply with the standard of care, procedures, and policies during and after the operation.
    c. Breach of duty to immediately remove the retained fragment of the drain in the surgical site, despite knowing that it would result in a surgical site infection requiring another surgery.
    d. Breach of duty by discharging the plaintiff without fully explaining the potential risks and complications of leaving the fragment behind and inside the plaintiff, and without undertaking the necessary interventions to safeguard their health and well-being.

102. DR. BECK, having a "physician-patient relationship" with VEGA has a fiduciary duty and responsibility to properly fulfill his obligations in good faith. The standard of care that he should have held is that of how he would treat himself if he was the patient.

103. A reasonable doctor faced with similar circumstances would not have allowed the fragment of the drain to remain and would have immediately taken steps to remove it.

104. He violated the fiduciary relationship between himself and Vega as the plaintiff, as Vega placed complete trust in Dr. Beck as a physician. This trust encompassed the expectation that Dr. Beck would provide proper supervision of treatment and facilitate healing.

105. And due to his deliberate acts, that caused harm, the Plaintiff's condition worsened and has resulted in prolonged pain and suffering, emotional distress and anxiety, loss of enjoyment of life, and a partial loss of income.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for the following relief:

a. Judgment in favor of the Plaintiff and against the Defendant on Counts I-VI of the Plaintiff's complaint, with an award for compensatory damages.

b. Judgment in favor of the Plaintiff and against the Defendant on Counts I-VI of the Plaintiff's complaint, with an award for punitive damages for acts on multiple occasions displaying outrageous conduct and reckless disregard for Vega's rights, safety, and interests. Such conduct is appropriately characterized as malice and reckless indifference.

c. An award for non-economic damages to the Plaintiff in an amount determined by the jury to be fair and reasonable.

d. An award for economic damages to the Plaintiff in an amount determined by the jury to be fair and reasonable.

e. An award for damages sought for loss of consortium realized by the compromised relationship with minor children.

f. An award for all the medical expenses incurred, and to be incurred in the future, by the Plaintiff.

g. That the Defendant IPFCF be held liable unto VEGA for the portion of this claim which is in excess of the limits expressed in *Wis. Stat. 655.23(4)* or the maximum liability limit for which the health care providers named herein are insured, whichever is greater.

h. Defendant IPFCF is liable unto Mr. Vega for the negligence of the health care providers, made Defendants herein under the auspices of *Wis. Stat. 632.24*, the Wisconsin Direct Action Statute.

i. VEGA seeks damages against defendant IPFCF in the amount to which he is found to be entitled plus interest, costs, and attorney's fees.

j. An award of prejudgment interest, attorney fees, costs, and post-judgment interest in favor of the Plaintiff and against the Defendant.

k. Any other legal and equitable relief that the Court deems just and necessary under the circumstances.

JURY DEMAND

The Plaintiff, Nestor Vega, demands trial by jury.

Dated this 31st day of August 2023.

The LaMarr Firm, PLLC

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EXHIBIT A