UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

ROBERT S. MELVIN,	***)***	
	)	
Plaintiff	***)***	
	)	
v.	***)***	***Docket No. 97-2-P-DMC***
	)	
UNITED STATES OF AMERICA,	***)***	
	)	
Defendant	***)***	

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND MEMORANDUM DECISION ON DEFENDANT'S MOTION TO EXCLUDE EXPERT TESTIMONY AND PLAINTIFF'S MOTION TO REOPEN TRIAL RECORD AND FOR SANCTIONS[1]

A jury-waived trial was held in this matter on July 20-23, 1998. The parties have submitted proposed findings of fact and conclusions of law. Prior to trial, the defendant filed a motion *in limine* seeking to exclude certain testimony of Irwin Goldstein, M.D., a board-certified urologist and professor of urology at Boston University School of Medicine who treated the plaintiff, specifically that testimony based on or reporting the results of "dorsal nerve somatosensory evoke potential" testing and "dorsal penile nerve conduction velocity" testing. Motion to Exclude Expert Testimony (Docket No. 33)[2] at 1, 8. After the completion of trial, and after the parties had filed their proposed

[1] Pursuant to 28 U.S.C. § 636(c), the parties have consented to have United States Magistrate Judge David M. Cohen conduct all proceedings in this case, including trial, and to order entry of judgment.

[2] The motion also seeks to exclude testimony of Clyde A. Niles, M.D., but Dr. Niles was not called as a witness by the plaintiff.

findings of fact and conclusions of law, the plaintiff filed a Motion to Reopen the Record . . . and for Sanctions ("Plaintiff's Motion to Reopen") (Docket No. 44), which included a request for hearing on the motion. In light of the defendant's response to that motion, as more fully discussed below, the plaintiff has withdrawn his request for a hearing. Because both pending motions affect the content of the record before the court, I will address them before setting forth my findings of fact and conclusions of law.

I. The Motion in Limine

The defendant's motion to exclude the testimony of Dr. Goldstein is based on *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). I received this testimony *de bene* at trial, *see Cortés-Irizarry v. Corporación Insular de Seguros*, 111 F.3d 184, 188 (1st Cir. 1997), and now deny the motion.

Daubert provides detailed guidance to a court considering a motion to exclude expert testimony under Fed. R. Evid. 702.

> Faced with a proffer of expert scientific testimony, . . . the trial judge must determine at the outset, pursuant to [Evidence] Rule 104(a), whether the expert is proposing to testify to (1) scientific knowledge that (2) will assist the trial of fact to understand or determine a fact in issue. This entails a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether the reasoning or methodology properly can be applied to the facts in issue.
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> Ordinarily, a key question to be answered in determining whether a theory or technique is scientific knowledge that will assist the trier of fact will be whether it can be (and has been) tested.
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> * * *
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> Another pertinent consideration is whether the theory or technique has been subjected to peer review and publication. Publication (which is but one element of peer review) is not a *sine qua non* of admissibility; it

> does not necessarily correlate with reliability, and in some instances well-grounded by innovative theories will not have been published. Some propositions, moreover, are too particular, too new, or of too limited interest to be published. But submission to the scrutiny of the scientific community is a component of "good science," in part because it increases the likelihood that substantive flaws in methodology will be detected. The fact of publication (or lack thereof) in a peer reviewed journal thus will be a relevant, though not dispositive, consideration in assessing the scientific validity of a particular technique or methodology on which an opinion is premised.
>
> Additionally, in the case of a particular scientific technique, the court ordinarily should consider the known or potential rate of error and the existence and maintenance of standards controlling the technique's operation.
>
> Finally, "general acceptance" can yet have a bearing on the inquiry. A reliability assessment does not require, although it does permit, explicit identification of a relevant scientific community and an express determination of a particular degree of acceptance within that community. Widespread acceptance can be an important factor in ruling particular evidence admissible, and a known technique which has been able to attract only minimal support within the community may properly be viewed with skepticism.

509 U.S. at 592-94 (citations and internal quotation marks omitted).

In the First Circuit, review of proposed expert testimony involves three "distinct but related requirements." *United States v. Shay*, 57 F.3d 126, 132 (1st Cir. 1995).

> First, a proposed expert witness must be qualified to testify as an expert by knowledge, skill, experience, training, or education. Second, the expert's testimony must concern scientific, technical or other specialized knowledge. Finally, the testimony must assist the trier of fact to understand the evidence or to determine a fact in issue.

Id., citing *Daubert* (internal quotation marks and citations omitted). Here, the defendant challenges Dr. Goldstein's testimony as insufficient on all three grounds, although it devotes most of its effort to the reliability requirement. The defendant argues that the two studies at issue have not been

presented in scientific journals, that they are experimental and have not been widely tested or reviewed, that the existence of a known error rate and standards controlling their operation have not been demonstrated, and that they are not generally accepted. Motion at 9-12. The latter point is supported by the affidavits of three urologists, one of whom testified at trial; all three aver that the evoke potentials test and the dorsal nerve conduction test "have not been documented to be accurate and commonly performed and are not reasonably relied upon by expert urologists in forming their opinions or inferences on either the standard of care for urological surgery cases or for urologists to appropriately and properly consider to assess injuries from improperly performed urological surgeries." Declaration of Drogo K. Montague, M.D. (Docket No. 36), ¶ 4; Declaration of Steven K. Wilson, M.D. (Docket No. 35), ¶ 4; Declaration of John J. Mulcahy, M.D. (Docket No. 34), ¶ 4. The plaintiff has offered the results of these tests, through Dr. Goldstein's testimony, to support his conclusion that both dorsal nerves on the plaintiff's penis have been damaged.

Dr. Goldstein testified that the evoke potentials test has been done by Dr. Daniel Sax, a board-certified neurologist who performed it on the plaintiff, since 1980 and that he works closely with Dr. Sax. He stated that this is a "very standard neurological test" for any body part. He acknowledged that the test is used on the penis only in "certain centers" and that not many doctors do it. He also stated that the test is used by his peers and its use in evaluating injuries to the penis has been presented at international medical meetings and in the literature. It is his practice to refer any patient with suspected nerve damage in the penis for this testing. Dr. Goldstein testified that the nerve conduction test performed on the plaintiff by Dr. Niles, a board-certified neurologist, is used "universally" in testing the penis and is conducted in non-academic settings. The plaintiff also submitted a list of published reports concerning both tests. Plaintiff's Memorandum in Opposition

to Defendant's Motion to Exclude Testimony (Docket No. 38) at 3 nn. 4&5 & Exh. 2.

I conclude that, on balance, the record contains sufficient indicia of the reliability of the tests upon which Dr. Goldstein relies in this case to meet the requirements of *Daubert* for their use in this case, satisfying the second element of the First Circuit's test for admissibility. The defendant's arguments concerning the first and third elements of the test for admissibility do not require extensive analysis. On the first element, the defendant asserts that Dr. Goldstein is not qualified to testify concerning the tests and their results because the tests were performed by neurologists and Dr. Goldstein is a urologist. Motion at 16. In the First Circuit, the fact that the testifying physician is not a specialist in the field in which he testifies goes to the weight of the evidence, not its admissibility. *Mitchell v. United States*, 141 F.3d 8, 15 (1st Cir. 1998) (testimony on standard of care). Dr. Goldstein's testimony established his familiarity with these tests and his frequent use of their results. On the third element, the defendant argues that there is no connection between this portion of Dr. Goldstein's testimony and the facts of the case because the tests do not show the location, time or cause of the injury to the nerve. Motion at 13-14. Dr. Goldstein did not rely on the tests as evidence of any of these things, but only to show that the dorsal nerves of the penis were in fact damaged. Since this is an element of the plaintiff's burden of proof, it should be obvious that testimony concerning the results of these tests will "assist [me] . . . to determine a fact in issue." *Shay*, 57 F.3d at 132.

"[A] district court enjoys substantial discretion to decide whether to admit or exclude relevant expert testimony." *Mitchell*, 141 F.3d at 15. Dr. Goldstein's testimony concerning the evoke potentials test and the nerve conduction test was admissible, and the motion to exclude it is **DENIED**.

II. The Motion to Reopen the Record and for Sanctions

Counsel for the plaintiff represents in this motion that he received after trial copies of medical records concerning the plaintiff maintained by the Department of Veteran Affairs ("VA") despite the defendant's representation before trial that all such records had been provided to him. The plaintiff seeks to reopen the record to add certain documents from that medical record to the evidence and also seeks sanctions for the defendant's failure to provide these records before trial, characterizing this failure as a fraud upon the court and an attempt to deprive him of a fair trial.

Memorandum in Support of Plaintiff's Motion to Reopen the Record and for Sanctions ("Plaintiff's Memorandum") (attached to Docket No. 44) at 3-6, 8. The defendant does not oppose the request to reopen the record in order to admit into evidence the documents attached to Plaintiff's Motion to Reopen and identified as pages 611-12, the documents attached to Defendant's Opposition, in Part, to Plaintiff's Motion to Reopen the Record (Docket No. 48) as Exhibit 1, pages 620-664, and the document attached to Plaintiff's Reply to Defendant's Response to Plaintiff's Motion to Reopen the Record and for Sanctions (Docket No. 52) and identified as page 665.

It is therefore **ORDERED** that the record shall be reopened solely for the purpose of adding to Exhibit 1 as admitted pages 611-612 and 620-665 identified above.

The plaintiff contends that he has been prejudiced by the failure of the defendant to provide these documents before trial and that he has somehow been "deprived of . . . the testimony of a Veterans Administration physician that in all likelihood would have provided testimony supportive of Plaintiff's claim," Plaintiff's Motion to Reopen at 2, by the defendant, all of which constitute grounds for the imposition of sanctions against the defendant. The sanctions sought are not specified, except that the plaintiff asks the court to consider "the possibility of the sanction of a

liability assessment against the Defendant." Plaintiff's Memorandum at 9. I have no difficulty in determining that the latter request, unsupported by citation to authority, far exceeds in severity an appropriate response to any of the defendant's alleged failures or omissions.

The plaintiff offers no explanation of his charge that the defendant deprived him of the testimony of a VA physician beyond a statement attributed to Sharon von Lentz, Ph.D. — not a physician — that she "would not be there for [the plaintiff] in this litigation." Plaintiff's Memorandum at 7. If this is indeed the person to whom the plaintiff's motion refers, there is no suggestion in the materials submitted by the plaintiff of any means by which the defendant supposedly prevented her from testifying. Certainly, the absence of her records from the materials provided by the defendant did not have this effect, since the plaintiff testified before receiving these records that a VA doctor had told him that the doctor would not testify. In the absence of any other information, I will not consider this particular claim further for any purpose.

The plaintiff alleges that the failure of the defendant to provide the subject documents, under the circumstances, constitutes a fraud upon the court.

> A "fraud on the court" occurs where it can be demonstrated, clearly and convincingly, that a party has sentiently set in motion some unconscionable scheme calculated to interfere with the judicial system's ability impartially to adjudicate a matter by improperly influencing the trier or unfairly hampering the presentation of the opposing party's claim or defense.

Aoude v. Mobil Oil Corp., 892 F.2d 1115, 1118 (1st Cir. 1989) (plaintiff fabricated purchase agreement that was basis of complaint). Here, the documents now admitted into evidence support and confirm the plaintiff's testimony, but they add nothing new. It is true that the defendant attempted to impugn the plaintiff's credibility, and that one or more of these documents might serve

to rebut the inferences that the defendant asked the court to draw in this regard. However, those circumstances do not necessarily lead to a conclusion that the absence of those documents, even if the result of an intentional scheme on the part of defense counsel, would interfere with an impartial adjudication of the plaintiff's claims or that it would hamper the presentation of the plaintiff's claim to a degree requiring the imposition of sanctions.

In addition, the plaintiff's conclusory allegation that the absence of these documents from the records provided to him, standing alone, establishes the existence of an intentional scheme to deprive him of a fair trial is unsupported by the record. The defendant has presented affidavits describing the efforts of defense counsel to obtain all of the VA's records concerning the plaintiff. The affidavits describe a hopelessly muddled bureaucratic morass in which maintenance of complete records is clearly not a priority. This does not excuse the failure of the defendant to provide complete records to the plaintiff when repeatedly asked to do so, nor does the choice of the plaintiff's counsel not to travel to the VA hospital at Togus to review the original records held there provide such an excuse, contrary to the defendant's argument. The failure to provide these documents diverted the time and attention of the court and counsel from the important issues of substance presented in this case and must not be condoned. If such failures were to continue, presenting a pattern of noncompliance by the VA in the future, or if a second such instance occurred in an ongoing case after the court had been made aware of one such failure, the conduct might well subject the VA or its counsel to imposition of sanctions, for a variety of reasons that may or may not include the basis asserted here by the plaintiff of fraud on the court.

In this case, the plaintiff has not established that the defendant perpetrated a fraud on the court. In addition, the defendant has not asked the court to find that the plaintiff fabricated his

testimony concerning his medical treatment in Arizona, *see* Defendant's Proposed Findings of Fact and Conclusions of Law (Docket No. 47); I make no such finding and would have made no such finding in the absence of these documents; and my conclusions of law do not rely upon an assessment of the plaintiff's credibility with respect to his seeking of medical care in Arizona or California. Under these circumstances, the motion for sanctions is **DENIED.**

III. Findings of Fact

1. The plaintiff is a 44-year-old military veteran, the father of two, who has not remarried since his divorce in 1990. He receives benefits based on a determination of 100% disability from the VA. He joined the Air Force at age 17 and was injured when he was struck by a pickup truck in 1971 while on active duty. His injuries in the accident were severe, including a fractured pelvis. He was hospitalized for seven months. Since the accident he has had pain in his back, pelvis, hips and thigh. Since 1971 he has been diagnosed with several psychiatric conditions, including bipolar disease, depression, lack of rage control, dependent personality and organic brain syndrome. His personality changed significantly after the accident. He retired from the military on disability.

2. In 1992, the plaintiff consulted Dr. Martyn Vickers at the VA facility at Togus, Maine after noticing problems with his erectile function that began sometime after his divorce. He could achieve only a partial erection, although it was sufficient to allow him to have intercourse and ejaculate. Dr. Vickers is now chief of surgery at Togus and practices urology with a subspecialty in impotence.

3. Dr. Vickers first prescribed oral medication for the plaintiff but the medication produced nausea. Dr. Vickers then prescribed a combination of another drug and papaverine injections during intercourse. The plaintiff failed to respond to this treatment. He could still have intercourse with

a partial erection, but increasing the dosage had no effect. Patients who fail to respond to this treatment usually have a problem with retention of blood supply in the penis. Dr. Vickers confirmed with testing that this was the case with the plaintiff.

4. After testing to be sure that the plaintiff's problem was organic rather than psychogenic, Dr. Vickers suggested venous ligation surgery, which involves severing and sealing the veins in the penis that are leaking blood. Dr. Vickers testified that he discussed the risks of this surgery with the plaintiff, who denies that he did so. Removal of the dorsal vein on the plaintiff's penis was the main goal of the surgery. Dr. Vickers performed this surgery on the plaintiff at a VA facility in Massachusetts on May 24, 1993. After the surgery, the plaintiff could still achieve a partial erection of the kind he was able to before the surgery, but there was no improvement. The plaintiff has not had intercourse since this surgery.

5. There are two dorsal nerves on the penis, located on either side of the dorsal vein, which runs along the upper (dorsal) side of the penis. Dr. Vickers did not disturb the dorsal nerves, which are in a thick sheath called Buck's fascia, during the plaintiff's ligation surgery. These nerves are the main nerves, or nerve trunks, from which progressively smaller nerves branch out over most of the penis.

6. Since he performed the plaintiff's ligation surgery, Dr. Vickers has learned that the success rate for this surgery has been determined to be very low and he no longer performs it. Venous ligation as a treatment for impotence was widely performed when the plaintiff's surgery was performed but is no longer generally used for this purpose.

7. Dr. Vickers then had the plaintiff try papaverine again but it failed to cause rigidity. He discussed other alternative treatments with the plaintiff and recommended a penile prosthesis, or

implant. The plaintiff chose a three-piece inflatable prosthesis. He signed a consent form for the implant surgery, although at the time of trial he did not recall signing it. The consent form was filled out by Dr. Reza Ghavamian, who also signed it. Dr. Ghavamian, who was then a urology resident under Dr. Vickers' supervision, discussed the risks of the implant surgery with the plaintiff when the consent form was signed, and was present when Dr. Vickers discussed the risks with the plaintiff in his office. Dr. Ghavamian recalled the signing of the consent form in this case because Togus required the signature of a third person, in addition to those of the patient and the physician explaining the procedure, on the consent form, and this was unusual in his experience. The plaintiff denied that the risks of the procedure were ever explained to him and suggested that both this form and the consent form for the venous ligation surgery were filled in after he signed them.

8. The installation of a penile prosthesis insures the loss of all natural erectile function.

9. The implant surgery was performed by Dr. Vickers on March 21, 1994 at Togus. Dr. Ghavamian was present during the surgery. Although Dr. Ghavamian had participated in one or two other penile implant surgeries at Togus, this was the first time he had performed such surgery with Dr. Vickers. For that reason, Dr. Vickers was very meticulous in taking Dr. Ghavamian through the steps of the procedure. It was a standard surgery, and neither physician recalls anything unusual about it.

10. The plaintiff recalled "typical post-surgical pain" while in the hospital following the implant surgery. The plaintiff's recovery from the surgery was uneventful. He recalled only one post-operative visit with Dr. Ghavamian on April 29, 1994, at which Dr. Ghavamian inflated the prosthesis and caused the plaintiff great pain by "pumping up the implant fast." The medical records reflect that the plaintiff's first post-operative visit took place on April 5, 1994. Joint Exhibit 1 ("Jt.

Exh. 1"), p. 367. Dr. Ghavamian told the plaintiff at this time about the risk of infection in the prosthesis, mentioning swelling, redness and discharge of purulent material as signs of infection. Dr. Ghavamian inflated the prosthesis at the second (4/29/94) post-operative visit. The plaintiff never inflated the prosthesis again.

11. The plaintiff testified that he "popped some stitches" in the surgical incision for the implant surgery while he was still in the hospital and that he reported this to Dr. Sloan, another urologist. The hospital record does not reflect such a report, *id*. pp. 190-275,[3] and according to Dr. Ghavamian, who examined the plaintiff frequently while he was still hospitalized, there "absolutely was not a hole in the plaintiff's scrotum" when he was released from the hospital.

12. On or about May 14, 1994 the plaintiff noticed that clear fluid was leaking from a hole in his scrotum. On the following day he saw a shiny black object in the hole. He waited until his May 17, 1994 (Tuesday) appointment at Togus, scheduled for evaluation of his stomach problems, to report this discharge because he was not having any unusual pain in the area and because he believed he could not get service at Togus on a weekend. According to the plaintiff's girlfriend at the time, Pamela Wildes, he went to Togus within a week after noticing the discharge. The medical record of the plaintiff's May 17 examination at Togus records that he reported first noticing the discharge two weeks earlier. *Id*. p. 302.

13. Dr. Ghavamian examined the plaintiff on May 17. He found a small opening at the center of the surgical incision, some redness, and a small amount of pus and noted that the tubing of the prosthesis was visible. When the device is showing through the skin, it is by definition infected. The

[3] The medical records do reflect a "gap in center of wound" noted by Dr. Sloan on May 21, 1994, *id*. p. 351, after the *explant* surgery.

plaintiff was informed that his prosthesis was infected. Infection of the prosthesis is a known risk of penile implant surgery that occurs in 1 to 6 per cent of all such surgeries.

14. Dr. Ghavamian considered the plaintiff's infection to present an emergent situation.[4] He informed the plaintiff that the implant would have to be removed, admitted him to the hospital, and started him on a course of intravenous antibiotics in preparation for surgery. The plaintiff testified that he signed a blank consent form for this surgery. According to Dr. Ghavamian, he obtained prior consent for the explant from the plaintiff, who signed the consent form in his presence.

15. The plaintiff contended that he assumed that Dr. Vickers would perform the explant surgery, but Dr. Ghavamian maintained that the plaintiff was aware that Dr. Vickers was not at Togus at the time. Dr. Vickers was then in San Francisco.

16. Dr. Ghavamian discussed the plaintiff's case with a urologist at the University of Massachusetts Medical Center and the then chief of surgery at Togus, who both agreed that explant surgery should be performed as soon as possible. While a medical student, Dr. Ghavamian had observed Dr. Goldstein, the plaintiff's expert witness, perform penile explant surgery, and he had performed one or two explants before performing the plaintiff's explant surgery. Explant surgery is much simpler than implant surgery because the incision is already made and the tubing of the prosthesis guides the surgeon to where he should be.

17. Because there was no urologist who performed penile prosthesis surgery available at Togus at the time, the chief of surgery assigned Dr. Arthur Pomerantz, a board-certified general surgeon, to "facilitate" the plaintiff's explant surgery. Dr. Ghavamian, as a resident urologist, could

[4] When there is infection in the penile prosthesis, gangrene can set in within hours or days. This can lead to loss of the penis and systemic infection throughout the body.

not perform the surgery without the presence of a supervising surgeon. Dr. Pomerantz had participated in two penile implant surgeries and two explants in 1980-81, during his surgical residency. He had observed Dr. Ghavamian to have very good skills in the operating room and considered him "eminently well-qualified" to perform this surgery. He knew that Dr. Ghavamian had participated in the surgery implanting the plaintiff's penile prosthesis.

18. Dr. Ghavamian removed the prosthesis on May 18, 1994 through the same incision made for the implant surgery, at the base of the penis on the side opposite the dorsal nerves. He removed the prosthesis without difficulty. He did not observe either dorsal nerve during the surgery.

19. The plaintiff testified that he saw Dr. Vickers on May 18 after the surgery and that Dr. Vickers asked him at that time if he wanted another implant. Dr. Vickers was in San Francisco on May 18. He first saw the plaintiff after his explant surgery on May 23, a date that is confirmed by the medical record. *Id*. pp. 354-55. According to Dr. Vickers, when a new prosthesis is installed after explant surgery, it is done four or five days after the explant surgery; one would not install a new prosthesis immediately after an explant due to the high risk of infection. The plaintiff did not report any numbness or pain to Dr. Vickers at this time. He told Dr. Vickers that he did not want another implant.

20. The pain that the plaintiff felt at first after the explant surgery was "standard surgical pain." He felt no numbness and no unusual pain while in the hospital. He did not return to Togus for his scheduled two-week follow-up after discharge from the hospital. In July 1994 he took a three-week trip with his son driving around the western part of the United States. During this time he felt pain at the site of the surgical scar as well as pain on the entire right side of the shaft of his penis. By the third week of July his penis was also numb on the right side. He requested an appointment at

Togus immediately upon his return from the trip and was given one two months later, in September. The plaintiff saw Dr. Vickers in September 1994. Dr. Vickers told the plaintiff that his pain was due to hypersensitivity and would go away.

21. In October 1994 the plaintiff started a relationship with a new girlfriend, who moved to Arizona with him in February 1995. He saw a psychologist regularly while in Arizona and also, in February 1996, consulted a VA urologist about his impotency and penile pain. According to the plaintiff, the urologist told him that nerves in his penis had been damaged. The urologist prescribed a vacuum device to assist the plaintiff in obtaining an erection, but the VA facility could not provide the device until June. The relationship with the girlfriend ended while the plaintiff was in Arizona.

22. The plaintiff moved to California in April 1996, where he also used the VA's health care services. He later returned to Maine, where he now lives with his mother and stepfather. He has had one failed romantic relationship with a woman since his return to Maine.

23. In October 1996 the plaintiff saw a Portland, Maine, urologist, Dr. Robert Timothy, who referred him to Dr. Goldstein in Boston. Dr. Goldstein performed pin prick and alcohol evaporation tests on the plaintiff's penis, to which the plaintiff did not respond. Biothesiometric testing revealed that the plaintiff required considerably more electrical stimulation to produce sensation along his penis than was required to produce sensation in his fingers. This testing convinced Dr. Goldstein that "something was wrong."

24. The finger is normally more sensitive than the penis on biothesiometry testing. The normal range for the penis is 7 to 8. A reading of 10, which the plaintiff recorded on both sides of his penis, is abnormal. Major nerve damage would be indicated by a value over 20 or 30.

25. Dr. Goldstein referred the plaintiff to Dr. Sax for evoke response potential testing. There

are not many doctors who perform this test on the penis, but it is a "very standard neurological test" for many body parts. It is used to identify a pathway from the penis to the brain. The result of the plaintiff's test was abnormal, well outside three standard deviations from normal. According to Dr. Goldstein, the test showed a 98.5% chance of nerve damage to the plaintiff's penis. The result implied that the plaintiff is not suffering from a systemic disease because only the penis evidenced neuropathy. According to Dr. Goldstein, this made the explant surgery "consistent as a cause" of the nerve damage.

26. Dr. Goldstein concluded that the plaintiff will suffer lifelong pain because the nerves will not regenerate, that the plaintiff's pain in his penis and scrotum was not caused by the 1971 vehicular accident, and that the plaintiff is not a candidate for another penile implant.

27. Dr. Goldstein also referred the plaintiff to Dr. Kenneth L. Blazier, an anesthesiologist at Mercy Hospital who runs the pain clinic there. The plaintiff reported pain from the midline to the left of the penile shaft and in his scrotum to Dr. Blazier. Dr. Blazier tried several drugs and performed two nerve blocks on the plaintiff in an attempt to deal with this pain. The plaintiff at the time of trial was taking a narcotic prescribed by Dr. Blazier that provided sporadic relief, but he testified that he is never without pain in his penis and scrotum.

28. The plaintiff began telling his mother about his penile pain when he returned from the car trip with his son in 1994. She was cognizant of his pain from the way he walked and his facial expressions, which indicated whether, at any given time, he was suffering from back pain or penile pain. He had difficulty sleeping, stayed at home and cried in his room. Medication controlled his rages. Since the 1971 auto accident, he could be happy one minute and depressed the next.

29. Christina Winter is a clinical psychotherapist who has been seeing the plaintiff every two

weeks. She testified that he has a dependent personality disorder and that, as a consequence, lack of a relationship with a woman creates anxiety and dysfunction for him. According to Winter, the plaintiff's major symptom is depression, and while he is very capable of living independently, he will not be happy doing it.

30. The plaintiff described the current pain in his scrotum as feeling like the skin is being torn off and the pain in his penis as feeling like a bad sunburn and sometimes like pins and needles. He currently masturbates to ejaculation about once a week. This causes pain.

31. The scrotum is served by a nerve bundle different from that which serves the penis. The scrotal nerve bundle branches off well above the point in the body where the nerve bundle serving the penis, including the dorsal nerves, does. According to Dr. Goldstein, the pain in the plaintiff's scrotum is due to nerve damage. An injury to the dorsal nerve in the penis would not cause pain in the scrotum.

32. When there is a surgical insult to a nerve, the report of pain occurs within a few days after surgery. The pain is immediately much more severe than surgical pain. If there is a lesser injury to the nerve, the report of pain might not be made for up to two weeks after surgery. Total dorsal nerve damage would make ejaculation impossible.

IV. Conclusions of Law

1. The plaintiff's claims in this case are limited to those arising out of the explant surgery conducted on May 18, 1994. Report of Final Pretrial Conference and Order (Docket No. 28) at 1.

2. The plaintiff argues that he is entitled to judgment on the basis of the doctrine of *res ipsa loquitur*. This issue is governed by state law. *Rolon-Alvarado v. Municipality of San Juan*, 1 F.3d

74, 79 (1st Cir. 1993). The doctrine is not available in medical malpractice cases under Maine law. *Caron v. Pratt*, 336 A.2d 856, 858 (Me. 1975). Even if that were not the case, this action does not present an appropriate occasion for application of the doctrine. Under Maine law,

> the doctrine of res ipsa loquitur is applicable where (i) there has been an unexplained accident, (ii) the instrument that caused the injury was under the management or control of the defendant and (iii) in the ordinary course of events, the accident would not have happened absent negligence on the part of the defendant.

Wellington Assoc., Inc. v. Capital Fire Protection Co., 594 A.2d 1089, 1092 (Me. 1991). Here, assuming *arguendo* that the plaintiff's injuries can be termed an "unexplained accident," the plaintiff has failed to prove the second element of the test, as is more fully discussed below. It remains unclear, after consideration of all evidence in the record, what instrument or action caused the plaintiff's injuries.

3. The plaintiff presented three theories of negligence in addition to his *res ipsa* argument: (i) the nerves causing his pain were injured during the explant surgery by cauterization; (ii) the nerves were sutured into the closure of the surgical incision; or (iii) the nerves were cut during the surgery. None of these explanations is sufficiently supported by the evidence to justify judgment for the plaintiff.

4. The dorsal nerves in the penis are located on the upper or dorsal side of the penis, the opposite side from the site of the surgical incision for the implant surgery on the ventral or under side, which was also used for the explant surgery. There is no testimony to the effect that the plaintiff's penile pain is due to injury to any nerves other than the dorsal nerves — that is, to one or more of the smaller nerves that branch off of the dorsal nerves — and such injuries are highly unlikely given the identical readings for both sides of the plaintiff's penis obtained by Dr. Goldstein's biothesiometry.

In addition, the damage that would cause the plaintiff's scrotal pain could only be damage to a third nerve which was not demonstrated by the evidence to be located near the site of the incision. In fact, the only evidence in the record concerning this nerve is that it is close to the nerves innervating the penis only much higher in the pelvic area than the surgical site.

5. Dr. Goldstein's biothesiometry readings also require a conclusion that the damage to both dorsal nerves is virtually identical, a conclusion uncontradicted in the record. This is another highly unlikely event if the damage occurred during the explant surgery. Dr. Vickers' testimony that such symmetrical readings would most likely result from an injury in the pelvis where the nerves are closest together, rather than in the penis and scrotum, is uncontradicted in the record.

6. The plaintiff testified that he felt no numbness or unusual pain while in the hospital after the explant surgery. He first felt pain and numbness consistent with nerve damage during his automobile trip in July 1994, at least six weeks after the surgery. This is apparently inconsistent with his report to Dr. Goldstein, upon which Dr. Goldstein relied in reaching his conclusions, that he felt shooting pain immediately after the surgery. There is no report of such pain in the medical records. Jt. Exh. 1 pp. 341, 345, 349, 353 (progress notes). The plaintiff also testified that he retains the ability to ejaculate. Both facts are inconsistent with severe damage to the dorsal nerves. Indeed, even lesser damage to these nerves should cause symptoms within two weeks after surgery, according to both Dr. Goldstein and Dr. Drogo K. Montague, the defendant's expert witness.

7. The plaintiff's loss of his pre-implant surgery ability to attain a partial erection is a consequence of the implant surgery, not the explant surgery, as both Dr. Goldstein and Dr. Vickers testified. As Dr. Goldstein put it, the plaintiff "signed off" on his ability to achieve an erection on his own when he "signed on" for the implant surgery.

8. The plaintiff's first theory of negligence, that the nerves were cauterized during the explant surgery, is based on Dr. Goldstein's testimony that the statement in the operative note from that surgery that "patient's bleeding points were all coagulated," *id*. p. 330, is suspect, when combined with the fact that there is no mention in the note that the nerves were protected or that the operative field was close to the urethra. He testified that he uses the cautery instrument employed in the plaintiff's explant surgery "extremely sparingly" in such operations. He testified that it is more risky to cauterize bleeding near a nerve than it is to wrap the penis in gauze and let the bleeding resolve. Dr. Montague testified that it is not possible to end bleeding in this area without coagulation by cauterization and that it would be substandard care to wrap the penis in gauze to control bleeding, a position also taken by Dr. Vickers. Dr. Pomerantz testified that Dr. Ghavamian used the cautery instrument appropriately during the explant surgery. Dr. Ghavamian testified that he used the cautery instrument only at the end of the surgery on minute bleeders on the surface of the corpus cavernosum. Dr. Vickers testified that he had observed Dr. Ghavamian's use of the cautery instrument hundreds of times before the explant surgery and that he had always used it appropriately. Based on the evidence in the record, I could find that the plaintiff's theory of negligence based on cauterization of his nerves is more likely than not the cause of his injuries only if it is more likely than not that both dorsal nerves had migrated from the dorsal side of the penis to the ventral side, close to the surgical site, a finding that is not justified by the record, *and* that a nerve innervating the scrotum was also damaged separately during cauterization on the surface of the corpus cavernosum, a finding for which there is no support whatever in the record.

9. The plaintiff's second theory of negligence, that the nerves causing his pain were sutured during the closing of the incision sites, is based on Dr. Goldstein's testimony that a suspect area in the

operative note is the statement "defects in corpus cavernosum were closed," *id*., with sutures, again in combination with the lack of a note concerning care to protect the nerves or that the operative field was close to the urethra. Dr. Vickers testified that the closure of the surgical site after the explant used a common technique within the standard of care. Significantly, Dr. Goldstein concludes that the closure was not within the standard of care only because the plaintiff subsequently reported pain consistent with nerve damage. This theory suffers from the same evidentiary defects as those discussed in connection with the theory based on cauterization.

10. The plaintiff's final theory of negligence, that the nerves causing his pain were cut during the surgery, is also based on Dr. Goldstein's testimony. Dr. Goldstein believes that this is the possible mechanism of injury because there is no mention in the operative note of protection of the nerves or visualization of the nerves. I do not accept Dr. Montague's testimony that such injury to the dorsal nerves during explant surgery is impossible. Nonetheless, this theory also suffers from the evidentiary defects discussed in connection with the first theory. In addition, I accept Dr. Vickers' testimony that he would not include in his operative note the fact that he avoided the dorsal nerves when they were not within his field of vision during a surgery on the ventral side of the penis as a reasonable explanation of the absence of such mention in Dr. Ghavamian's operative note for the explant surgery. Dr. Vickers was training Dr. Ghavamian.

11. Judgment for the plaintiff on any of his theories of negligence in this case would require that I engage in speculation in order to find causation. The inference that the plaintiff's injuries occurred in any of these three ways is not supported by a preponderance of the evidence, and I decline to draw any such inference under the circumstances.

12. In the absence of a finding of causation, the plaintiff's additional contentions that it was

below the applicable standard of care for Dr. Pomerantz to supervise the explant surgery and that the plaintiff should have been sent to another hospital where a practicing urologist could have performed the surgery are irrelevant. In addition, to the extent that the plaintiff contends that the surgery was performed without his informed consent, I credit the testimony of Dr. Ghavamian that he did obtain such consent from the plaintiff and the testimony of several of the physicians that it is standard practice for resident physicians to obtain such consent.

13. On a number of occasions, my findings of fact have noted conflicts in the testimony about certain details such as the number of post-implant follow-up visits by the plaintiff, whether consent forms for each surgery were signed before or after they were filled in and whether the risks of each surgery were explained to the plaintiff, and when certain events occurred. Wherever I have reported differences in the factual recollection of various witnesses, I have chosen to credit one version over another only when the issue involved was central to this case. When it was necessary for me to resolve these conflicts in order to reach the conclusions of law set forth above, I have made such resolutions explicit. To the extent that these disputes were resolved against the version reported by the plaintiff, those resolutions in no way reflect a determination that there was any intent on the part of the plaintiff to be less than fully truthful in his testimony. Rather, I conclude that the differences reflect the effects of the passage of time and the fading of memory.

In light of the foregoing, judgment shall enter in favor of the defendant.

So ordered.

Dated this 23rd day of September, 1998.

David M. Cohen
United States Magistrate Judge