IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR SUSSEX COUNTY

SARA POLLARD-MARCUS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	C.A. No. 06C-02-012-RFS
	)	
DOUGLAS J. FORCUCCI,	)	
	)	
Defendant.	)	

MEMORANDUM OPINION

Upon Plaintiff's Motion for New Trial or Additur. Denied.

Submitted: January 24, 2007
Decided: February 8, 2007

H. Clay Davis, III, Esquire, Georgetown, Delaware, Attorney for Plaintiff.

Jeffrey A. Young, Esquire, Young & McNelis, Dover, Delaware, Attorney for Defendant.

STOKES, Judge

This is a personal injury case where Douglas J. Forcucci (hereinafter "Defendant" or "Forcucci") admitted liability but contested the nature and extent of injuries suffered by Sara Pollard-Marcus (hereinafter "Plaintiff" or "Pollard-Marcus"). After evidence and argument, the issues were submitted to the jury late in the afternoon of January 17, 2007. After deliberating for about one and one quarter hours, the jury returned the next morning at 9:00 a.m. At about 11:30 a.m. on January 18, 2007, the Court reconvened, and the jury announced its verdict of one-thousand dollars. Thereafter, Plaintiff moved for a new trial or, in the alternative, for additur under Civil Rule 59. The Defendant opposes the motion. For the reasons set forth herein, the Motion is denied.

LEGAL PRINCIPLES

The principles on a motion of this nature are too well established to require any citation. A jury verdict is presumed to be correct and is entitled to great deference. It will not be altered unless the award is clearly tainted by passion, prejudice, partiality or corruption. A judgment will be set aside when it is grossly disproportionate to the injuries suffered so as to shock the Court's conscience and sense of justice. A verdict will only be ignored where the evidence weighs so heavily against it that a reasonable jury would not have returned the result. In this analysis, one must be sensitive to constitutional requirements that only juries decide questions of credibility, and their verdicts represent community judgments about the merit and value of cases. That is the Delaware - if not the American - way of the civil justice system.

BACKGROUND

On March 3, 2004, Plaintiff was stopped at a traffic light on Route 24 near Plantation Road in Sussex County. Defendant was also stopped at the light; both parties waiting for the traffic light to change. Defendant did not pay attention and when the light turned to green he accelerated, striking the rear of Plaintiff's vehicle. The collision caused Pollard-Marcus' vehicle to, in turn, strike an S.U.V.

Pollard-Marcus claimed to be dazed and hurt by the accident. She was holding her head immediately following the accident. Forcucci spoke with Plaintiff but did not observe her to be in obvious distress. Plaintiff drove her car to work at the GAP store in the Rehoboth Outlets. She was a retail manager there. After opening the store, she went to the Beebe Medical Center Emergency Room (hereinafter "BMC"). There she was diagnosed as suffering cervical strain with acute neck pain, given a neck collar, and prescribed muscle relaxants and pain medication. Plaintiff was referred to her primary care physician for any follow-up treatment. At that time, her family doctor was J. Brian Prigg (hereinafter "Prigg").

Plaintiff did not see Prigg until March 25, 2004. Prigg's notes assess Plaintiff's condition as "neck pain." Medication was prescribed and an M.R.I. of the cervical spine was ordered. Plaintiff was excused from work.

Plaintiff returned to Prigg on April 8, 2004. Shoulder pain was recorded by Prigg in the following manner: "the onset of the pain has been sudden and has been occurring in a persistent pattern for 2 days." At that time, the neck was found to be "exquisitely tender,"

and a "decreased range of motion" was noted. There was localized swelling in the left shoulder area, and Plaintiff complained of pain associated with movement of the shoulder. An additional diagnosis of Rotator Cuff-Syndrome of Shoulder and Allied Disorders was given. Plaintiff was given a steroid injection into the left shoulder on April 8, 2004. Prigg referred her to Dr. Ronald Sabbagh (hereinafter "Sabbagh"), an orthopedic specialist, to further evaluate her neck. Sabbagh prescribed physical therapy sessions that Plaintiff has attended.

Plaintiff again visited Prigg's office on April 19, 2004. Prigg's examination at that time found Plaintiff's neck to be "mildly" tender. A decrease in range of motion was reported. No swelling was observed in Plaintiff's left shoulder and there was "no decrease in range of motion, pain on movement or restriction in abduction."

In her May 25, 2004 visit to Prigg's office, Plaintiff reportedly said her "shoulder and neck are doing better. Has one session left of physical therapy." A physical examination found her neck was "normal," and her condition concerning the shoulder and neck was found to be "improved." No new shoulder issues were noted.

Thereafter, Plaintiff was seen by Prigg on August 24, 2004. There was a lump under her arm which was not related to the accident. However, upon physical examination, her neck was "supple." Plaintiff was given Ambien for sleeping difficulties. Plaintiff described the onset as gradual over the preceding five months. In prior office visits, no complaints of changes in sleeping patterns had been reported.

Plaintiff returned to Prigg on September 15, 2004 for, what she described as, an "acute follow[-]up." A change in sleeping pattern was reported. On physical examination, Plaintiff's neck was "supple." In her left shoulder, there was decreased range of motion with painful movements. Plaintiff reported having seen Sabbagh and Dr. Mohammad Medhi (hereinafter "Medhi") but stated that she "want[ed] another opinion" concerning her shoulder.

On December 28, 2004, Plaintiff had complaints about persistent itching, arising five days before. The condition was diagnosed as "allergic rhinitis, cause unspecified." On physical examination, the neck was "supple," and the neck pain condition was "improved." No shoulder complaints were noted, and no sleeping pattern disturbances were reported.

Plaintiff saw Sabbagh as recommended by Prigg. On April 14, 2004, Sabbagh documented Plaintiff's complaints about left shoulder and neck pain following her accident. On examination, Sabbagh found that she "[had] a fairly full ROM of the neck, neg Spurlings [sic] maneuver to the rt and lt." M.R.I.'s of her cervical spine and left shoulder were reviewed. Sabbagh's impression was: "(1) Disc herniation C6-C7 which I believe has no sig clinical sx., and (2) Bursitis/RC tendinitis lt shoulder." Sabbagh believed that most of Plaintiff's symptoms arose from her shoulder and not her neck. A subacromial injection was done, and physical therapy prescribed. She was kept out of work until the physical therapy was completed because her job required overhead lifting. Sabbagh cautioned Plaintiff not to have chiropractic care given because of her disc herniation. Sabbagh also recommended

that Plaintiff not resume chiropractic care until the symptoms were resolved.

On her return visit to Sabbagh, Plaintiff reported that the injection stopped working after several days. On examination, Sabbagh noted that "she [Plaintiff] continues to maintain a full ROM of her neck with a negative Spurling's maneuver to the rt and lt." His impression was noted as "RC Tendinitis, lt shoulder." Plaintiff was to return after completion of physical therapy and was to stay out of work until then.

On the return visit of May 28, 2004 to Sabbagh, Plaintiff complained of terrible shoulder pain. The doctor was not sure what was causing it. The M.R.I. of the shoulder was "essentially normal," and Sabbagh's records indicated that she had "a very small, tiny disc herniation at C6-C7 which [Sabbagh did] not think [was] causing any clinical problems." Plaintiff was referred to Medhi for pain management. Thereafter, a return to work order with no restrictions was approved on June 1, 2004. However, after Plaintiff complained of continuing pain, the order was modified to provide for one-half days work pending Medhi's visit and completion of a functional capacity evaluation.

Thereafter, Medhi examined her. In the medical records of a visit on July 5, 2004, pending litigation was noted. On palpation, no trigger points or muscle spasms were noted. There was some tenderness over the neck and shoulder area. A Spurling's test caused medium neck pain on left side without radicular pain. The medical report referenced the M.R.I. done on August 8, 2004 which revealed bursitis in the left shoulder. With this study, it was noted that there were "hypertrophic changes of the AC jt along with an anterior

inferior hook in the acromion which would predispose a significant increased risk for impingement. Rotator cuff tendons are otherwise normal without evidence of an underlying tear." Medhi confirmed that the accident caused a whiplash soft tissue injury which may temporarily cause chronic pain. Medhi felt most of the pain complaints resulted from the shoulder impingement syndrome and "less likely from her C spine." However, Medhi noted that an E.M.G. nerve conduction study would be helpful to rule out cervical radiculopathy.

On July 12, 2004, Dr. William J. Barrish (hereinafter "Barrish") performed a nerve conduction and E.M.G. procedure. The nerve conduction results were normal (except for the left elbow). The E.M.G. involved the use of needles, and it was not complete because the test was too difficult for Plaintiff to tolerate. Barrish made the following assessments: "(1) left sided neck pain and left shoulder pain with no evidence for left cervical radiculopathy; (2) [i]ncidental finding of mild left ulnar neuropathy at the elbow; (3) [l]eft shoulder impingement syndrome." Plaintiff was to follow up with Mehdi. Plaintiff, however, did not continue treating with Medhi or Sabbagh; deciding instead to seek another opinion.

Concerning the Functional Capacity Evaluation (hereinafter "FCE"), it was done on June 25, 2004 by Southern Delaware Physical Therapy (hereinafter "Southern Delaware"). In its report to Sabbagh, Southern Delaware concluded that Plaintiff "appeared to give reliable effort during [the] FCE. She demonstrated the ability to perform activities in the Light Physical Demand Classification except for overhead activities."

Southern Delaware had given Plaintiff physical therapy treatment as ordered by Sabbagh on April 14, 2004 for left rotator cuff syndrome, tendinitis. She had seventeen treatments. A Southern Delaware record of Plaintiff's May 26, 2004 treatment session reported her saying there was "80% progress, no medication the past three weeks, ROM is good but I have weakness." The therapist made this assessment: "Patient has made measurable gains. Improved deficits. Partially met her long term goals."

On June 22, 2004, Plaintiff was discharged from Southern Delaware because she did not continue with therapy. At that time, Plaintiff reported increased neck and shoulder pain while working with only minimal improvement from therapy.

Thereafter, on August 12, 2005, Plaintiff went to BMC because of shoulder pain. The BMC record reported in two places that there was a sudden onset of pain the night before when Plaintiff tried to extend her arms forward while carrying something heavy at work. On physical examination, there was normal range of motion in the neck. A radiology study of the left shoulder revealed no evidence of fracture, dislocation, or of evolving degenerative or inflammatory arthritic changes. BMC's diagnosis was shoulder sprain.

On August 16, 2005 Plaintiff was seen by Dr. Truman B. Volatile (hereinafter "Volatile"), an orthopedic specialist. He found a full range of motion in her neck. After reviewing x-rays and M.R.I.'s of her left shoulder, and cervical spine, Volatile found an impingement syndrome on the left shoulder. An orthroscopic examination was recommended to fix or rule out a lateral tear and then to proceed with subacromial

decompression to address the impingement syndrome. He felt that the disk herniation at C6-C7 was more on the right side, and while it may be the cause of some of Plaintiff's shoulder pain, it was not believed to be the primary source of the problem . According to Volatile, such herniations generally do not cause shoulder pain.

On October 13, 2005, Plaintiff was examined preoperatively. She continued to complain of pain in her left shoulder associated with overhead use. On October 21, 2005, orthroscopic surgery was done. Plaintiff did not have a rotator cuff tear or lateral tear at that time. According to the operative report, she had "a definite impingement with a prominent anterior hook of the acromion but no rotator cuff tear." Subacromial decompression was done. Initially, she was limited to light duty for three weeks and scheduled for physical therapy. After sixteen visits at Tidewater Physical Therapy, Plaintiff reached maximum benefit and was released to resume full duty on January 2, 2006.

On August 16, 2006, Volatile found that Plaintiff had "full range of motion in her left shoulder with minimal discomfort." She complained about "pain and rigid motion over her neck." Volatile believed another shoulder surgery might be helpful and referred Plaintiff for a pain management consultation. On October 10, 2006, Dr. Manonmani Antony, a pain management specialist, saw Plaintiff. He felt Plaintiff suffered from "cervical facet syndrome superimposed with severe para spinal muscle spasm."

On September 19, 2005, Plaintiff had an evaluation with Dr. Bikash Bose (hereinafter "Bose"), a neurosurgeon. He recommended that further studies be done in light of her

continuing complaints. An M.R.I. of the cervical spine was done on November 28, 2005. Bose's impression was: "[d]egenerative changes consistent with uncinate process hypertrophy at C3-C4 and C4-C5. Small protrusions are seen on the left side at C2-C3, central at C5-C6 and to the right side at C6-C7."

On January 5, 2006, a nerve conduction study was done together with needle insertion EMG studies by Dr. Anthony L. Cucuzzella (hereinafter "Cucuzzella"). His interpretation was: "No evidence of cervical radiculopathy, neuropathy or plexopathy, both upper extremities."

Thereafter, Bose met with Plaintiff on February 17, 2006. He reviewed the previous work-up. Plaintiff was complaining of "neck pain and shooting sensations at the left side of her neck and down into her arms." Bose recommended a cervical myelogram with postmyelogram CT. Bose added that a provocative cervical discography may also be needed. Plaintiff chose not to pursue any of Bose's suggestions.

At trial, Plaintiff offered the testimony of Dr. Stephen J. Rodgers (hereinafter "Rodgers"). He is an occupational medical doctor and has a law degree. Rodgers evaluated Plaintiff at the request of Plaintiff's attorney. He was not a treating physician, but was paid for the evaluation. In essence, Rodgers' opinion was that Plaintiff suffered permanent injuries from the accident, prominently including cervical spine strain with cervical herniated nucleus and left shoulder post traumatic impingement syndrome. He felt that all the physical therapy, chiropractic care, and Plaintiff's complaints were related to the accident.

ANALYSIS

The jury was given the standard instructions, including: that determinations regarding the credibility of witnesses are made exclusively by the jury, that medical opinion must be based on reasonable medical probability, that expert testimony is to be judged by factors bearing on reliability, that Plaintiff had the burden of proof to show the nature and extent of all injuries caused by Defendant, that it must be more probable than not that the damages found to exist were caused by the incident in question, and that the decision would have to be based on the evidence and law. The parties agree that Plaintiff was impaired to some degree in the accident. Consequently, the jury was instructed to return a verdict greater than zero.

What makes this case somewhat unusual is that Defendant did not introduce medical expert testimony by way of a defense medical examination while Plaintiff used a consultant physician. There is no requirement for a defendant to do so; a plaintiff always bears the burden of proof. If there is a basis in the evidence, a jury can find a litigant, and a lay or expert witness, not to be worthy of belief. As later explained, there was medical evidence from Plaintiff's treating physicians and providers (who did not testify but their medical records were admitted) upon which a jury could find against Plaintiff.

As previously stated, it is not the Court's role to make determinations of credibility - rather the evidence must be reviewed to see what a rational jury could find. From the record, the jury could find Plaintiff's credibility to be suspect. By finding Plaintiff's credibility to

be wanting the jury could appropriately discount her alleged injuries. The verdict represents an assessment of this nature.

In this regard, Plaintiff claimed to be hurt in the impact. Defendant, however, did not observe a problem. During deliberations, the jury asked if it could use a police report in reaching a decision. Perhaps the jury was looking for the observations of a neutral observer, like a police officer, to make its decision easier between the respective positions of the parties. Of course, the Court advised the jury to reach a verdict only on the evidence introduced at trial under the instructions of the law. Given the result, it is clear that the jury did not find Plaintiff to be credible (i.e., Plaintiff did not immediately request medical care and was capable of going to work; she told Mehdi on July 5, 2004 that her car was "totaled," while she, in fact, drove it to her place of employment).

Evidence from studies of her shoulder supports the inference that the herniated disk did not contribute to her complaints. Based on examinations and objective tests, such as palpations, Spurling's maneuvers, and the many diagnostic studies, Sabbagh, Mehdi and Volitile found that her pain was related to the shoulder impingement and not her neck. The E.M.G. studies taken by Barrish and Cucuzzella eliminated cervical radiculipathy.

Further, an M.R.I. study found the left shoulder to be "essentially" normal except for the impingement syndrome with tendinitis. Medical evidence suggests that impingement is a structural problem ready to happen which can be triggered by repetitive movements of the arm lifting heavy objects. This mechanism of injury was consistent with the nature of

Plaintiff's work. Even Rodgers conceded this point on cross examination. Rodgers also agreed that there were degenerative findings in Plaintiff's neck and shoulder area typical of an aging person. The BMC record of the August 12, 2005 incident involving Plaintiff's shoulder corroborates these assessments. The pain came on suddenly while lifting something heavy at work. There was evidence of bursitis in the shoulder which can be seen as related to the syndrome.

Additionally, Plaintiff did not fare well in the course of trial. Her initial treatment with a chiropractor was recommended by a friend. Sabbagh cautioned against it. When asked about what appeared to be important information about her condition, she appeared to be evasive. For example, she denied knowing that the first M.R.I. was of no clinical significance to her complaints. She claimed not to be aware of the finding about bursitis and did not know the initial E.M.G. results. She did not have a plausible explanation for the absence of shoulder complaints in Prigg's August 24, 2004 record when such would ordinarily be expected. A jury could find her responses were less than candid. Pollard-Marcus gave a strong impression of being the kind of person who would be keenly aware of her health at all times.

Further, when contrary to her personal injury claims, Plaintiff took issue with her treating providers. They had her medical interests in mind and were trying to help her. For example, Plaintiff disagreed with the physical therapist's positive assessments about her recovery in a previously referenced May 26, 2004 note. Plaintiff denies telling BMC

personnel that there was a sudden onset of left shoulder pain on August 12, 2005 arguing that the two notations in the medical record were wrong.

Moreover, on August 16, 2006 Volatile found that she had a full range of motion with minor discomfort as a result of the shoulder surgery. Plaintiff's response to this was that Volatile was "highly inaccurate" and that she had very serious doubts about his treatment. As the case unfolded, Pollard-Marcus had a pattern of disagreeing with medical opinions which did not support her litigation claims.

Likewise, Rodgers was not credible from the perspective of a rational jury. He could be seen as a veritable Paladin. He treats few patients. Rodgers largely testifies for claimants in worker's compensation cases and mostly for plaintiffs in personal injury litigation. Unlike Plaintiff's treating doctors, Rodgers had little contact with Plaintiff. In the past, he was suspended from medical practice. He was quick to volunteer that he was a pioneer in the field of pain management, a person ahead of the times who had too many arrows in his back. However, it appeared he lacked objective, professional judgment in the face of patient demands. A rational jury could find that his opinions were driven to pay the proverbial piper and could disregard them *in toto*. *See Beatty v. Smedley*, 2003 WL 23353491 (Del. Super. Mar. 12, 2003).

In this case, a rational jury could conclude that Plaintiff had a whiplash injury with soft tissue complaints which resolved in a short period of time. Prigg's notes of May 25, 2004 concluded that Plaintiff's neck pain had improved. There was "no neck stiffness" and

physical examination of the neck noted it to be "normal." The BMC record from the date of the accident (March 3, 2004) noted "cervical strain, [and] no other injury." Complaints about disrupted sleeping patterns do not appear until August 24, 2004. Prigg's records note symptoms of this nature under the category "[p]sychiatry." A jury could find that Plaintiff had not previously reported them, and they were unrelated to the Forcucci incident.

In this context, the award of one thousand dollars ($1000) is not arbitrary or tainted by impermissible factors. It does not shock the conscience of the Court. Rather, given the length of its deliberations, the jury carefully considered the evidence and law, and its verdict is supported by sufficient evidence. Essentially, Pollard-Marcus failed to prove her case by credible evidence while records from her treatment providers provided a neutral basis to find only whiplash and soft tissue injury. As has been frequently observed, litigation is not risk free.

CONCLUSION

Considering the foregoing, the motion is denied. Because an offer of judgment was filed, and the final verdict amounts to less than that offer, costs are assessed against Plaintiff under Superior Court Civil Rule 68.

IT IS SO ORDERED.

cc: Prothonotary