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IN THE IOWA DISTRICT COURT FOR SCOTT COUNTY

THE ESTATE OF KATHLEEN HAZEN, by STEVEN J. HAZEN, Administrator, and STEVEN J. HAZEN, individually, Plaintiffs, GENESIS HEALTH SYSTEM d/b/a GENESIS MEDICAL CENTER, and WILLIAM E. OLSON, M.D., Defendants.	)	LAW NO. LACE130055 **PLAINTIFFS' TRIAL BRIEF**

COME NOW, Plaintiffs, by and through their attorneys, Anthony J. Bribriesco and William J. Bribriesco of the BRIBRIESCO LAW FIRM, PLLC, and for their Trial Brief state:

INTRODUCTION

Kathleen Hazen ("Kathy") underwent a laparoscopic cholecystectomy ("Gallbladder Surgery") performed by Dr. William E. Olson ("Dr. Olson"). Kathy alleges that Dr. Olson breached the standard of care during the Gallbladder Surgery by failing to place a mechanical device on her cystic artery and cystic duct causing her to bleed out. Kathy alleges that Dr. Olson and Genesis Medical Center ("Genesis") were negligent in the management and monitoring of Kathy's

coagulation status. Kathy further alleges that Dr. Olson and Genesis were negligent in their failure to diagnose and timely treat Kathy's internal bleeding.

Dr. Olson and Genesis's negligence caused Kathy's hemorrhagic shock, ischemic stroke, multi-system organ failure, and ultimately, her death.

Kathy suffered pre-death physical, mental, and emotional damages as a result of Dr. Olson's and Genesis's negligence.

Kathy's spouse, Steven J. Hazen ("Steve") is also claiming loss of spousal consortium due to Kathy's death resulting from the negligence.

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STATEMENT OF FACTS

1. Leading up to surgery, Kathleen Hazen ("Kathy") was taken off the "blood thinners" or anticoagulation medication that she was on.

2. Specifically, Kathy stopped taking the anticoagulation medication of Coumadin leading up to her surgery.

3. Kathy had been placed on Coumadin as a result of having a mechanical aortic valve.

4. On February 2, 2016, Kathy's cardiologist cleared her for surgery and Kathy stopped taking Coumadin pursuant to her cardiologist's orders.

5. On February 8, 2016, Defendant William Olson, M.D., removed Kathy's gallbladder ("the Gallbladder Surgery.")

6. Dr. Olson did the Gallbladder Surgery at Mercy Medical Center ("Mercy Hospital") in Clinton.

7. On February 13, 2016, Kathy returned to the emergency room at Mercy Hospital with symptoms of abdominal pain and vomiting.

8. The medical providers at Mercy Hospital ordered the following tests:

a. CT Scan of the abdomen; and

b. HIDA Scan.

9. The medical providers at Mercy Hospital suspected that something had gone wrong with the Gallbladder surgery.

10. Specifically, the medical providers suspected that there was bile leaking inside of Kathy.

11. Bile is a fluid that helps with digestion.

12. Bile is stored in get gallbladder and Kathy's gallbladder was removed during the Gallbladder surgery.

13. The medical providers at Mercy Hospital transferred Kathy to the Genesis Medical Center ("Genesis") to fix the bile leak.

14. On February 14, 2016, Kathy became a patient of Defendant Genesis.

15. On February 14, 2016, Kathy underwent an endoscopic retrograde cholangiopancreatography ("ERCP") and a stent was placed.

16. As early as February 15, 2016 and February 16, 2016, Kathy was bleeding internally. (Trial Brief Exs. 1-11)

17. On February 15, 2016, Kathy was experiencing signs and symptoms of internal bleeding, and her are few:

a. Kathy is in severe pain despite being on extremely power narcotics.

b. Kathy is in server pain despite the bile leak being fixed.

c. A CT Scan of Kathy's abdomen is taken and there is abnormal findings of fluid or "ascites" in her abdomen.

d. The lab results for blood showed a critical drop in hemoglobin[1] and hematocrit[2].

18. The Genesis's hospitalists and Dr. Olson breached the standard of care when they failed to timely diagnose internal bleeding and properly address/treat Kathy's internal bleeding. (Trial Brief Exs. 1-11)

19. On February 16, 2016, one of the hospitalists at Genesis gave Kathy the blood thinner of Coumadin.

20. Anticoagulation medications interfere with the body's process to "clot" or coagulate.

21. The hospitalists at Genesis violated the standard of care when they gave Kathy Coumadin instead of a different anticoagulation medication called Lovenox. (Trial Brief Exs. 1-11)

22. Coumadin should **not** have been given to Kathy because Coumadin is too difficult to regulate how "thin" or "thick" Kathy's blood was given the circumstances. (Trial Brief Exs. 1-11)

[1] A hemoglobin test measures the amount of hemoglobin in your blood. Hemoglobin is a protein in your red blood cells that carries oxygen to your body's organs and tissues.
[2] A hematocrit test measures the proportion of red blood cells in the blood. Red blood cells carry oxygen to your body's organs and tissues. So, a decrease in hematocrit is a sign of loss of blood.

23. The risk is if the blood is too "thin," then Kathy's body may start to bleed and/or not be able to form a clot anywhere Kathy is already bleeding.

24. The lab results that measure how "thin" or "thick" blood are called International Normalized Ratio ("INR") levels.

25. Kathy's INR levels were erratic while she was a patient at Genesis.

26. The Genesis's hospitalists and Dr. Olson violated the standard of care when they failed to properly monitor and manage Kathy Hazen's coagulation status.

27. By the time of February 22, 2016, seven had days passed. On this date, Kathy was taken back to the operating and there was 3 to 4 liters of blood – approximately the equivalent of a gallon of blood – in Kathy's abdomen where it should not be.

28. Kathy loss of blood resulted in her body going into shock because her organs were not getting enough blood and oxygen ("hemorrhagic shock")

29. As a result of going into hemorrhagic shock, Kathy's organs started to fail one after the other and this is called "multi-system organ failure." For example, Kathy was intubated and placed on a mechanical ventilator because her lungs had failed. For another example, Kathy was hooked up to a continuous dialysis machine called "CRRT" because her kidneys had failed.

30. On February 29, 2016, Kathy was transferred to the University of Iowa.

31. On March 12, 2016, Kathy died.

32. There was an autopsy report done and the cause of death was hemorrhagic shock due to the Gallbladder surgery.

33. The source of bleeding was from the cystic artery, a location where Dr. Olson operated on during the Gallbladder Surgery. (Trial Brief Exs. 1-11)

34. Dr. Olson violated the standard of care by not putting a mechanical device on Kathy's cystic artery during the Gallbladder Surgery. (Trial Brief Exs. 1-11)

LEGAL PRINCIPLES

This is a medical malpractice case, and the legal elements are:

a. establishing the applicable standard of care;

b. a violation of this standard; and

c. causal relationship between the violation and the injury sustained.

Oswald v. LeGrand, 453 N.W.2d 634, 635 (Iowa 1990); *see also Susie v. Fam. Health Care of Siouxland, P.L.C.*, 942 N.W.2d 333, 337 (Iowa 2020).

Upon proving the above elements, Plaintiff is entitled to damages. The questions respecting the violation of a standard of care and the causal relationship are issues for the trier of fact. *See Speed v. State*, 240 N.W.2d 901, 904 (Iowa

1976). A plaintiff is required to identify the specific acts or omissions relied upon to generate questions for the trier of fact. *See Herbst v. State*, 616 N.W.2d 582, 585 (2000) (en banc).

Expert testimony is required to establish that the applicable standard of care was breached and to create a jury question on causation when the causal connection is not within the knowledge and experience of an ordinary layperson. *Susie v. Family Health Care of Siouxland*, P.L.C., 942 N.W.2d 333, 337 (Iowa 2020); *Peppmeier v. Murphy*, 708 N.W.2d 57, 61–62 (Iowa 2005); *see also Phillips v. Covenant Clinic*, 625 N.W.2d 714, 718 (Iowa 2001) (expert testimony is necessary to "establish the existence of a causal relationship between [the] breach" and the alleged damages); *McCleeary v. Wirtz*, 222 N.W.2d 409, 413 (Iowa 1974) ("[C]ausal connection is essentially a matter which must be foundationed upon expert evidence."). While an expert is not required to express an opinion with absolute certainty, the jury cannot be left to speculate about the but-for causal link. *Susie*, 942 N.W.2d at 338-39; s*ee Ranes v. Adams Labs., Inc.*, 778 N.W.2d 677, 688 (Iowa 2010; *see also Hlubek v. Pelecky*, 701 N.W.2d 93, 96 (Iowa 2005).

Generally, negligence is the "failure to use ordinary care." *Bartlett v. Chebuhar*, 479 N.W.2d 321, 322 (Iowa 1992). Physicians have a duty of care to their patients to apply that degree of skill, care, and learning ordinarily possessed and exercised by other physicians in similar circumstances. *Speed v. State*, 240

N.W.2d 901, 904 (Iowa 1976). "A physician owes a duty to his patient to exercise the ordinary knowledge and skill of his or her profession" when providing care and treatment. *Eisenhauer v. Henry Cty. Health Ctr.*, 935 N.W.2d 1, 18 (Iowa 2019) (*citing J.A.H. ex rel. R.M.H. v. Wadle & Assocs*., P.C., 589 N.W.2d 256, 260 (Iowa 1999). As a general rule, expert testimony must be provided which shows that the physician has breached their standard of care. *Perin v. Hayne*, 210 N.W.2d 609, 613 (Iowa 1973).

Dr. Olson thus owed a duty to exercise "the ordinary knowledge and skill" of his profession during the laparoscopic cholecystectomy, and if that standard was violated, he is liable for injuries. *See Eisenhauer v. Henry Cty. Health Ctr.*, 935 N.W.2d 1 (Iowa 2019). Physicians have a duty to exercise "the ordinary knowledge and skill" of their profession when they administer and monitor medications provided to their patients and ensure the proper medications are administered in light of the circumstances and medical history of each patient. Thus, if that duty is breached, the hospital is liable for injuries resulting from that breach.

ARGUMENT

I. The preponderance of the evidence proves that Defendant William E. Olson. M.D. ("Dr. Olson") breached the standard of care.

a. Dr. Olson failed to safely perform the Gallbladder Surgery.

Kathy began experiencing abdominal pain and went to the hospital to figure out what the problem was. After diagnostic testing was done, it was determined that Kathy had gallstones. She was referred to Dr. William E. Olson, M.D. ("Dr. Olson") Dr. Olson told Kathy that it was a "simple procedure." (Trial Brief Ex. 12, S. Hazen Dep. Tr. 39:08-15) In Kathy's case, her medical history mattered, and made this "simple procedure" a little less simple.

In 2012, Kathy underwent an aortic mechanical replacement and mitral valve repair. After this surgery, Kathy was placed on *Coumadin* by her treating cardiologist. *Coumadin* is a medication used to treat blood clots and/or prevent new clots from forming in the body.

Because of Kathy's heart condition, prior to her gall bladder surgery, she went to see her cardiologist. On January 18, 2016, Kathy underwent a coronary angiography. After this procedure, Kathy's cardiologist cleared her for her laparoscopic cholecystectomy ("Gallbladder Surgery") to be performed by Dr. Olson.

Dr. Olson Failed to use a Clip on the Cystic Artery

Dr. Olson chose to perform the surgery with a harmonic scalpel *without a clip* to support the cystic artery at the time of the gallbladder surgery. This decision was a breach in the standard of care and led to Kathy's demise. (Trial Brief Exs. 1-11)

Because of Kathy's heart condition and need for anticoagulant medication, Kathy was at a higher risk of bleeding. Dr. Olson should have considered that and used a clip on the cystic artery for compression to slow down the blood flow and support her body's coagulation process. (Trial Brief Exs. 9-11, Dr. Shpiner Suppl. Rpt. p. 5)

Dr. Gardiner is board-certified in general surgery. (Trial Brief Ex. 7) Dr. Gardiner establishes that the standard of care required Dr. Olson to place a mechanical device on Kathy's cystic artery given her medical history, particularly because Dr. Olson knew or should have known that Kathy would be anticoagulated very soon after the operation. (Trial Brief Exs. 6-7, Dr. Gardiner Suppl. Rpt. p. 2)

It is undisputed that Dr. Olson did not place a clip on Kathy's cystic artery during the gall bladder surgery. Dr. Olson's position is that a clip (or other mechanical device) was not necessary because he used a Harmonic scalpel to perform the surgery and that device would have been enough to cut and seal the cystic artery.

Except for Dr. Olson choosing not to use a clip or loop to occlude the cystic artery, Kathy would not have suffered from hemoperitoneum resulting in 3-4 liters of blood from her peritoneal cavity causing her hemorrhagic shock, multisystem organ failure, and her death. (Trial Brief Exs. 1-11, Dr. Breall Suppl. Rpt., Dr. Gardiner Suppl. Rpt., Dr. Shpiner Suppl. Rpt. p. 4)

Dr. Olson Failed to use a Clip on the Cystic Duct

Dr. Gardiner establishes that the standard of care required Dr. Olson to place a mechanical device on Kathy's cystic duct rather than using the Harmonic scalpel only. (Trial Brief Ex. 7, Dr. Gardiner Dep. Tr. 28-30) Dr. Gardiner is not aware of any surgeons who do not use some form of clip or occlusion on the cystic duct after its division. (Trial Brief Ex. 7, Dr. Gardiner Dep. Tr. 30) The mechanical device would have secured the duct and not have it open up. (Trial Brief Ex. 7, Dr. Gardiner Dep. Tr. 33)

It is undisputed that Dr. Olson did not place a clip on Kathy's cystic duct during the gall bladder surgery. Dr. Olson's position is that a clip (or other mechanical device) was not necessary because he used a Harmonic scalpel to perform the surgery and that device would have been enough to cut and seal the cystic duct. Dr. Olson breached the standard of care by failing to place any form of mechanical occlusion on the cystic duct. (Trial Brief Ex. 7, Dep. Gardiner Dep. Tr. 32:02-33:17)

Because Dr. Olson failed to place a clip (or tie) on the cystic duct, and Kathy's higher risk of bleeding, Kathy bled from the cystic artery and entered hemorrhagic shock, causing her to suffer an ischemic stroke, and die. (Trial Brief Exs. 1-11, Dr. Breall Suppl. Rpt., Dr. Gardiner Suppl. Rpt., Dr. Shpiner Suppl. Rpt.)

b. Dr. Olson failed to timely diagnose that Kathy was internally bleeding and provide proper treatment.

Defendant Dr. Olson breached the standard of care when he failed to identify or diagnose internal bleeding. (Trial Brief Exs. 1-11) Defendant Dr. Olson breached the standard of care when he failed to investigate signs and symptoms of internal bleeding. (Trial Brief Exs. 1-11)

Dr. Olson breached the standard of care by failing to recognize the red flags indicating bleeding. (Trial Brief Exs. 1-11) When Kathy had her CT on 2/15/16, the CT was abnormal and should have raised suspicions of internal bleeding due to the moderate ascites and large amount of free air. (Trial Brief Exs. 1-11) Kathy's INR levels were also profoundly erratic. (Trial Brief Ex. 9)

Dr. Olson breached the standard of care by failing to properly investigate by ordering a paracentesis and arteriogram. (Trial Brief Ex. 6)

Dr. Olson Failed to order a Paracentesis

Dr. Olson also breached the standard of care when he failed to test or order testing of the fluid in Kathy's abdomen ("paracentesis"). (Trial Brief Ex. 9)

Specifically, Dr. Shpiner opined that,

> Dr. Olson breached the standard of care by not ordering a paracentesis of the ascites/fluid after receiving the results of the CT of the abdomen and pelvis performed on February 15, 2016. He should have ordered a paracentesis under ultrasound guidance. **More likely than not the lab results of the paracentesis would have indicated that the ascites/fluid in question was blood.** The CT scan of the abdomen and pelvis on February 15, 2016, noted, "a moderate amount of ascites". The CT scan of the abdomen and pelvis on February 22, 2016, under Impressions stated, "1. Increased free fluid of high attenuation since 1 week ago consistent with a bile leak, probably persistent." The emergency laparotomy performed on February 22, 2016, resulted in the removal of 3-4 liters of blood from the abdomen, and not bile.

(Trial Brief Ex. 9, emphasis added) The paracentesis would have allowed Dr. Olson to diagnose Kathy with internal bleeding; thus, Dr. Olson breached the standard of care.

Dr. Olson Failed to order an Arteriogram

Further, Defendant Dr. Olson breached the standard of care when he failed to order an arteriogram and consult with an interventional radiologist, which would have allowed Dr. Olson to provide the proper treatment for the internal bleeding.

Specifically, Dr. Gardiner opined that given the anticoagulation Kathy was receiving, she was likely bleeding as of February 15, 2016. (Trial Brief Ex. 6)

> [T]he standard of care would then have required Dr. Olson to begin a search for an active bleeding site by requesting a selective arteriogram of the common hepatic artery. If that arteriogram confirmed ongoing bleeding and identified an active bleeding site (in this case most likely the stump of the cystic artery), an interventional radiologist could have deployed micro-coils into the bleeding site during that arteriogram to permanently occlude the bleeding source. In addition to directing this therapy, Dr. Olson would also have had an obligation to communicate with the physicians at Genesis who were responsible for managing/adjusting Ms. Hazen's anticoagulation.

(Trial Brief Ex. 6) After discovering there was bleeding with the paracentesis, had Dr. Olson ordered the arteriogram, it would have prompted an interventional radiologist who could have deployed micro-coils into the bleeding site to permanently stop the bleeding. If such treatment had been rendered, Kathy would not have died. (Trial Brief Ex. 6) Thus, Dr. Olson breached the standard of care when he failed to timely and properly address/treat internal bleeding and caused Kathy's death. (Trial Brief Exs. 1-11)

c. Dr. Olson failed to safely manage Kathy's coagulation status.

Defendant Dr. Olson breached the standard of care when he failed to properly/safely monitor Kathy's coagulation status. Dr. Olson had a duty to communicate with the physicians at Genesis who were responsible for managing/adjusting Kathy's anticoagulation. (Trial Brief Ex. 6)

Defendant Dr. Olson breached the standard of care when he failed to properly manage Kathy's medication. (Trial Brief Exs. 1-11)

Defendant Dr. Olson breached the standard of care when he failed to use the proper anticoagulation medication. (Trial Brief Exs. 1-11)

The failure to safely manage Kathy's coagulation status was a contributing cause of Kathy's death. (Trial Brief Exs. 1-11)

II. The preponderance of the evidence proves that Defendant Genesis Medical Center ("Genesis") breached the standard of care by failing to diagnose and administer the proper medication for Kathy Hazen.

a. Defendant Genesis breached the standard of care when it failed to identify and diagnose internal bleeding.

Defendant Genesis breached the standard of care when it failed to identify and diagnose internal bleeding. (Trial Brief Exs. 8-11) Defendant Genesis breached the standard of care when it failed to investigate signs and symptoms of internal bleeding. (Trial Brief Exs. 8-11) Defendant Genesis breached the standard of care when it failed to test or order testing of the fluid in Kathy's abdomen ("paracentesis"). (Trial Brief Exs. 8-11)

Specifically, Dr. Shpiner opined that Dr. Ductan of Genesis breached the standard of care by "not ordering a paracentesis of the ascites/fluid after receiving the results of the CT of the abdomen and pelvis performed on February 15, 2016. She should have ordered a paracentesis under ultrasound guidance. More likely than not the lab results of the paracentesis would have indicated that the ascites/fluid in question was blood. The CT scan of the abdomen and pelvis on February 15, 2016, noted 'a moderate amount of ascites.'" (Trial Brief Exs. 9)

b. Defendant Genesis breached the standard of care when it failed to timely and properly address/treat internal bleeding.

Defendant Genesis breached the standard of care when it failed to timely and properly address/treat internal bleeding.

If such treatment had been rendered, Kathy would not have died. (Trial Brief Ex. 6) "Under paracentesis, they would have discovered blood days earlier than they did, and more likely than not, in all medical probability, would have prevented her from hemorrhaging to death." (Trial Brief Ex. 11) Genesis's failure to order diagnostic testing and failure to find the source of bleeding led to Kathy's death.

c. Defendant Genesis breached the standard of care when it failed to properly monitor and manage Kathy's coagulation status.

Defendant Genesis breached the standard of care when it failed to safely/properly manage anticoagulation medication. Defendant Genesis breached the standard of care when it failed to give the proper anticoagulation medication.

Specifically, Dr. Shpiner opines that Dr. Ductan of Genesis breached the standard of care by managing Kathleen Hazen's anticoagulation in an unsafe manner. (Trial Brief Ex. 9) Dr. Ductan had a responsibility to balance Kathleen's risk of bleeding versus clotting. (Trial Brief Ex. 9) It was the standard of care to use Lovenox (Enoxaparin) when Kathleen was admitted to Genesis Medical Center. Lovenox safely regulates a patient's ability to coagulate. (Trial Brief Ex. 9) It is a stable and effective bridge and therefore there is no urgency to get a patient back on Coumadin, a more unstable medication. (Trial Brief Ex. 9)

Dr. Ductan chose to use Coumadin (Warfarin), which takes up to 48 hours to impact the INR level of a patient, instead of using Lovenox, which is administered

twice a day subcutaneously, allowing for closer monitoring. In addition, Lovenox effects are easier to reverse. (Trial Brief Ex. 9) The choice to use Coumadin instead of using Lovenox following the ERCP caused Kathleen Hazen's INR level to be erratic. Dr. Ductan breached the standard of care when she ordered the use of Coumadin while Kathleen Hazen was not in a steady state. Kathleen Hazen was on antibiotics, NPO after a procedure, and was receiving blood products. Dr. Ductan knew or should have known that you do not use Coumadin unless you have a patient in a steady state. (Trial Brief Ex. 9)

Furthermore, Dr. Ductan did not consider that Kathy had also been given an antiplatelet medication (aspirin). (Trial Brief Ex. 4, p. 38) Dr. Breall opined that Dr. Patel of Genesis breached the standard of care by "not factoring into his plan of treatment that [Kathy] had been given aspirin rectally on February 13, 2016." (Trial Brief Ex. 2) Aspirin is another agent that facilitates bleeding. (Trial Brief Ex. 4, p. 68)

Thus, Defendant Genesis breached the standard of care when it failed to properly manage and monitor Kathy's coagulation status. (Trial Brief Exs. 9-11)

Defendant Genesis breached the standard of care when it failed to exercise a degree of skill, care, and learning ordinarily possessed and exercised by hospitals in similar circumstances. (Trial Brief Exs. 9-11) Dr. Ductan's choice to use

Coumadin for Kathy violated the standard of care and was a contributing cause of her death. (Trial Brief Ex. 9)

III. The jury may award damages to Kathy Hazen for pre-death physical, mental, and emotional damages.

The jury may also award Kathy damages for her pre-death physical and mental pain and suffering from the date of the injury to the time of her death. In *Holmquist v. Volkswagen of Am., Inc*., 261 N.W.2d 516, 525-26 (Iowa Ct. App. 1977), the Court of Appeals of Iowa held:

> [P]ain and suffering which the law allows is not confined to mere physical aches. It includes as well the mental anguish, the sense of loss and burden and the inconvenience and embarrassment which a person who is materially crippled or disabled in body or limb can never escape.

While duplicate damage awards are to be avoided, "each case must be evaluated according to the evidence peculiar to it alone." *Holmquist, Inc., supra,* 261 N.W.2d at 525-26; *see also Poyzer v. McGraw*, 360 N.W.2d 748, 753 (Iowa 1985). So long as the jury award is "within the scope of the evidence adduced," there is no reason to disturb the award. *Holmquist, Inc., supra,* 261 N.W.2d at 525-26.

In this case, Kathy suffered significant physical and mental pain and suffering as a result of the negligence of Dr. Olson and physicians at Genesis.

> Dr. Olson's surgical report, of February 22, 2016, noted 3 liters of blood in Kathleen Hazen's abdomen. As a result, blood was not getting to the organ systems in Kathleen's body. The average female body has 4.0 - 4.5 liters of blood. Consequently, Kathleen had a loss of approximately seventy-five (75%) of her blood volume between February 15, 2016, and February 22, 2016. Ninety percent (90%) of people die when they lose the amount of blood that Kathleen Hazen lost.

> On February 23rd, Ms. Hazen experienced seizure like activity. A CT scan revealed she had suffered large left-sided-posterior cerebral infarction without hemorrhage.

(Trial Brief Ex. 9) Kathy suffered an ischemic stroke, multi-system organ failure, and hemorrhagic shock. (Trial Brief Ex. 9) Kathy suffered pain, fear, uncertainty, and many more mental and physical symptoms throughout her time at Genesis from February 14 – March 11, 2016, when she died. Therefore, the jury may determine an award for pre-death physical, mental, and emotional damages.

IV. The jury may award damages to Kathy's husband, Steven J. Hazen, for loss of spousal consortium.

Spousal consortium is "the fellowship of husband and wife and the right of each to the intangible benefits of company, cooperation, affect, and aid of the other in every marital relationship." *Gail v. Clark*, 410 N.W.2d 662, 667 (Iowa 1987). Spousal consortium "also includes the tangible benefits of general usefulness, industry, and attention within the home and family." *Id*. Loss of consortium is a separate property right of a spouse who suffers the loss of aid, services, support, companionship and affection as a result of injuries caused to their spouse by Defendants. *Bergfeld v. Unimin Corp*., 226 F. Supp. 2d 970, 982-83 (N.D. Iowa 2002). Loss of consortium claims must be joined with the injured party's claim whenever feasible. *Madison v. Colby*, 348 N.W.2d 202, 209 (Iowa 1984). In order to prove a claim for loss of consortium, a husband does not need to show the defendants caused separate bodily injuries to him— he only needs to show that the

defendants are liable to his wife. *Bergfeld, supra*, 226 F. Supp. 2d at 983; *Pekin Ins. Co. v. Hugh*, 501 N.W.2d 508, 510 (Iowa 1993).

Here, Kathy's husband has suffered a loss of consortium and the jury may determine what the monetary amount in the verdict.

CONCLUSION

A reasonable jury will find that Defendants were negligent, and that Plaintiffs are entitled to damages.

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PROOF OF SERVICE

I certify that this document was served upon all parties to this case by delivering it to the attorney(s) of record at their addresses as shown by the pleadings on January 17 _____, 2023, by:

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