PPM ANESTHESIA MALPRACTICE INSURANCE

ANESTHESIA & the LAW

A PROFESSIONAL LIABILITY NEWSLETTER FOR ANESTHESIOLOGISTS PRESENTED BY

PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP, INC.

ISSUE 15

Wrongful Death Case: New York Defense Verdict

A Long Island, New York jury recently returned a defense verdict in a wrongful death case following spine surgery. There were no meaningful settlement discussions prior to trial based on the strength of our defense. Settlement value was estimated by counsel at approximately $550,000 to $600,000.

The patient, a 55 year-old female was previously diagnosed with spinal stenosis and presented for a laminectomy and spinal fusion. The patient's medical history was significant for depression, hypothyroidism, hypertension, irritable bowel syndrome, pancreatitis, reflux disease and asthma. The patient was on numerous medications and had an extensive surgical history including open heart surgery for repair of a congenital septal defect. Medical clearance was provided by the patient's primary care physician.

Following an uneventful 3.5 hour surgery performed under general anesthesia provided by a PPM insured anesthesiologist and CRNA, the patient was sent to recovery while still intubated. Upon arrival the patient was administered oxygen via the endotracheal tube with an oxygen saturation of 97 percent, recorded blood pressure of 142/47 and a pulse of 89. Shortly after arriving in recovery, a nurse noted bilateral anterior wheezes. The anesthesiologist was called, an aerosol treatment was initiated and shortly thereafter the patient became bradycardic. The anesthesiologist declared a code, but the patient did not survive. An autopsy concluded that the death resulted from hypertensive and arteriosclerotic cardiovascular disease.

Plaintiff, the surviving husband, sued the surgeon, the primary care physician and the PPM insured anesthesiologist and CRNA. During the course of the trial, plaintiff dismissed a number of named defendants including the CRNA, while continuing his case against the anesthesiologist. Plaintiff's primary theory at trial was that the patient suffered a pneumothorax which the anesthesiologist failed to diagnose and treat. Plaintiff's attorney presented the testimony of a pathologist to argue that a pneumothorax had resulted from barotrauma, despite an absence of evidence that such trauma had occurred. The plaintiff also called an anesthesiologist, Norman Ernst, MD, to support his claim that the failure to diagnose and treat the alleged pneumothorax was below the standard of care (due to a peculiarity of New York law, expert witnesses are not deposed prior to trial and therefore a transcribed account of their opinions is not available).

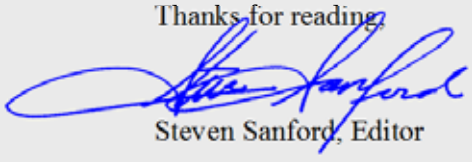
The absence of any indication of barotrauma was the primary focus of the anesthesia defense. Defense experts also explained that to the extent a pneumothorax had occurred; alternative, non-negligent explanations were available. For example, chest compressions and needle placement during the code could cause a pneumothorax.

The six-person jury returned a unanimous defense verdict in less than one hour. Bruce Brady of New York, New York defended the case on behalf of the PPM policyholders and Wade Willard, Senior Claims Attorney managed the file on behalf of PPM. ❖

In this Issue

As illustrated by several of the cases reported in this issue, it remains relatively easy for plaintiff attorneys to advance questionable lawsuits. Despite efforts to pursue the recovery of costs following defense verdicts, most cost recoveries are insignificant when compared to our defense costs. Absent more meaningful sanctions, there are few deterrents for plaintiffs filing frivolous lawsuits.

Thanks for reading,



Steven Sanford, Editor

Ulnar Nerve Damage: Kentucky Defense Verdict

A defense verdict in Louisville, Kentucky is the latest in a string of 37 upper extremity nerve damage cases successfully tried by PPM. Since approximately 1998, PPM has aggressively defended upper extremity nerve damage cases, primarily those involving injuries to the brachial plexus and ulnar nerves. After developing a comprehensive defense strategy, PPM has established an impressive trial record; thirty-seven defense verdicts, zero verdicts for plaintiffs.

Our most recent case involved a 58 year-old male patient with a history of pain in his 4th and 5th fingers. The patient underwent a right carpal tunnel release based on a pre-operative EMG that indicated an entrapment of the median nerve. The carpal tunnel release was performed using an axillary block administered by a PPM insured anesthesiologist. Following surgery, the patient experienced numbness in his hand and the inability to move his ring and little finger. On follow-up the hand surgeon diagnosed an ulnar nerve injury and suggested to the patient that the injury most likely occurred when the anesthesiologist provided a supplemental block near the ulnar nerve. The patient was treated conservatively for approximately six months, before undergoing a surgical exploration of the ulnar nerve.

Litigation was filed and focused on the hand surgeon's testimony that the injury most likely occurred during the administration of a supplemental block. The PPM insured anesthesiologist testified that no supplemental block was performed in this case, nor was the administration of such blocks part of her normal practice.

Plaintiff's anesthesia expert, Franklin Segal, MD, testified that the most likely explanation for the injury, in his opinion, was through placement of a supplement block that directly struck the ulnar nerve. According to Dr. Segal, other causes of the nerve injury could be ruled out. The medical records document that the patient was positioned appropriately and the tourniquet pressure was recorded at 280 mmHG while inflated for only 25 minutes.

Plaintiff also relied heavily on the testimony of the treating hand surgeon, Joseph Kutz, MD. According to Dr. Kutz, while he did not see the anesthesiologist perform a supplemental block, he came to the conclusion that a supplemental block was performed based on scarring to the ulnar nerve observed during the second surgical procedure.

The defense of the anesthesiologist focused on alternative theories to explain the ulnar neuropathy. According to the defense expert the ulnar nerve injury in this case could have been the result of the tourniquet pressure or other unknown causes that are reflected in the medical literature, including a persuasive Mayo Clinic Study. Finally, the defense discounted the likelihood that a supplemental block was the source of the injury by noting that had such direct trauma occurred, the patient's reaction would have been noted by everyone in the operating room.

In addition to the anesthesia testimony, the defense also offered the testimony of a hand surgeon who opined that, in his opinion, an improperly placed tourniquet used during the surgery was the more likely cause of the injury.

The jury in this case deliberated for 1.5 hours prior to returning a defense verdict. Before trial, the plaintiff had offered to settle the case for $225,000. No offer was made on behalf of the PPM insured anesthesiologist.

Ron Sheffer of Louisville, Kentucky defended the case on behalf of the anesthesiologist. Shelley Strome, Senior Claims Specialist managed the file on behalf of PPM. The court awarded costs to PPM in the amount of $934 on defense costs of $107,000. ❖

Intubation Injury: Missouri Defense Verdict

A jury in Clayton, Missouri returned a defense verdict in favor of an anesthetist accused of negligent intubation resulting in an arytenoid dislocation.

The patient, a 58 year-old female with a prior history of heavy smoking for numerous years, underwent an exploratory laparotomy for a suspected bowel obstruction. General anesthesia was administered by a PPM insured CRNA supervised by a PPM insured anesthesiologist. According to the anesthesia providers the intubation was atraumatic and performed on one attempt. Approximately 19 days following the procedure the plaintiff complained of hoarseness and was subsequently diagnosed with an arytenoid dislocation and underwent a resection.

In her lawsuit against the anesthesia providers, the plaintiff alleged our insured dislocated her arytenoid during a traumatic intubation. Plaintiff's anesthesia expert was Michael Grossman, MD of Denver, Colorado. Dr. Grossman's

deposition testimony was read into evidence at the time of trial. According to Dr. Grossman based on his review of the records this was an easy intubation and accordingly an arytenoid dislocation should not have occurred. Therefore, in his opinion, the fact that a dislocation occurred equates to a deviation from the standard of care.

The defense offered the testimony of William Owens, MD of St. Louis, Missouri. Dr. Owens testified that recent literature is fairly clear that most cases of this type do not actually involve a dislocation of the arytenoid, but rather a scarring of the surrounding tissue which forces the cartilage out of place and holds it there. While the intubation may have contributed to the condition, Dr. Owens testified that in his opinion subluxation did not occur directly from placement of the endotracheal tube. Moreover, Dr. Owens did not believe that an adverse outcome in this regard is indicative of negligence.

Plaintiff's theory was further undermined by the testimony of the patient's subsequent treating otolaryngologist. The otolaryngologist testified that he also does not believe that arytenoid dislocations are the result of traumatic intubation. Instead, such injuries are simply an anomaly that can occur from time to time even when the intubation is performed with the best of care. The otolaryngologist testified that his opinions were supported by research he has conducted with dogs in which he was unable to dislocate the arytenoid even with the forceful use of a metal bar.

The jury deliberated for one hour prior to returning a defense verdict. Prior to trial the plaintiff had made a demand of $100,000. No settlement offers were extended on behalf of PPM's insureds. This case was tried by Gregory Minana of St. Louis, Missouri. Shelley Strome, Senior Claims Specialist managed the file on behalf of PPM. Cost in the amount of $2,203 were collected by PPM from the plaintiff. ❖

Wrongful Death: Texas Defense Verdict

The patient, a 74 year-old male, presented for total right knee replacement with epidural anesthesia and light sedation via LMA administered by a PPM insured anesthesiologist. The procedure and anesthesia were uneventful and the patient was transferred to the recovery room. The epidural was left in for post-operative pain management and the patient was eventually transferred to the floor. The anesthesiologist was contacted approximately five hours later and was informed that the patient was in a great deal of pain. Consistent with the anesthesiologist's standing orders and usual protocol, the patient received 4 mg of Morphine and the epidural catheter rate was increased to 16cc per hour.

The anesthesiologist was again contacted approximately two hours later and informed that the patient was still having pain and was showing signs of confusion and agitation. The anesthesiologist ordered the nurses to hold the epidural infusion until the patient became fully awake and could be reassessed. He also directed the nurses to call him once this had occurred. The anesthesiologist came to the hospital at approximately 8:00 pm when informed that the patient was awake. Based on his assessment, the anesthesiologist elected to leave the epidural catheter in place based on the patient's complaints of pain and the repositioning pain that would result from removing the catheter. The anesthesiologist indicated that the epidural catheter would be removed the following day and ordered the nurses to administer 2 to 4 mg of Morphine per two hours as necessary.

At approximately 3:00 am the following day, while attending to an obstetrical case, a code was called and the same anesthesiologist responded. Upon arrival the patient was in full code but could not be resuscitated.

Plaintiff, the wife of the deceased patient, filed suit against the hospital and the health care providers involved in the patient's care, including the PPM insured anesthesiologist. In the lawsuit, the plaintiff claimed that the anesthesiologist was negligent in his failure to: properly and timely assess and diagnose the patient's respiratory and/or cardiac depression; to prescribe and order administration of proper and timely anesthetic and/or analgesic medications following surgery; to properly and timely administer resuscitation medications and procedures; and to timely and properly obtain consultation and advice from appropriate health care providers.

Despite the allegations, the plaintiff's own anesthesiology expert was not critical of the choice or dosage of the medications administered. At this point, the plaintiff changed her theory against the anesthesiologist and alleged there was a failure to order appropriate monitoring of the patient while the patient was receiving sedatives and opiates given the risk of respiratory depression and hypoxia.

A defense expert retained on behalf of the anesthesiologist was fully supportive of the care and treatment provided. This defense expert was also supportive of the monitoring performed by the nursing staff. In addition, a cardiologist retained for the defense testified that, in his opinion, the cause of death was unrelated to the medications

administered by the anesthesiologist. According to this cardiologist the cause of death was sudden cardiac arrhythmia. The cardiologist ruled out respiratory depression based on the timing of the medications and the nursing records that did not reflect signs of over sedation or respiratory depression. In addition, the autopsy findings demonstrated that the patient's heart was abnormally enlarged and weighed 460 grams (a normal heart would weigh 280 to 340 grams). In addition the patient had thickened heart muscle and a 90 percent blockage of the left coronary artery. Based on these findings, the cardiologist indicated that such patients, especially those with a significant history of hypertension, frequently die as a result of sudden cardiac arrhythmia. Finally, the cardiologist noted that had the patient experienced respiratory depression, he would have anticipated that the patient's wife, who was at the patient's bedside, would have noted the labored breathing along with infrequent and loud respirations.

Prior to trial, plaintiff had demanded $850,000 to settle this case. The anesthesiologist in consultation with PPM refused to consent to settlement. Following a six day trial, the twelve-person jury returned a unanimous defense verdict on behalf of all health care providers. Michael Stewart of Dallas, Texas defended the anesthesiologist. Brian Thomas, Senior Claims Attorney managed the file on behalf of PPM. PPM obtained a judgment to collect costs from plaintiff in the amount of $3,500 on defense costs exceeding $150,000. ❖

Dental Injury: Rare Dental Trial Results in Defense Verdict

Given the limited damage potential associated with dental injuries following general anesthesia, it is rare for plaintiff attorneys to pursue such cases. The contingency fee in typical dental cases is generally prohibitively low. In addition, because dental injuries are a recognized risk of general anesthesia and typically disclosed to the patient during the informed consent process, obtaining a plaintiff's verdict is difficult.

This New York case involved a 40 year-old female patient scheduled for shoulder surgery. After a period of conservative treatment failed, the patient underwent a decompression acromioplasty and inspection of the rotator cuff under general anesthesia. According to the anesthesia records the patient's front tooth was fractured upon emergence from anesthesia. The PPM insured anesthesiologist testified that the dental injury did not occur during intubation or extubation. Instead, the anesthesiologist suspected that "chattering" during emergence was the cause of the injury and explained that thermodynamic changes experienced during emergence could result in this type of injury. The cost of repair was estimated at $950 by the patient's own dentist.

Plaintiff did not present an anesthesia expert and instead relied on a "res ipsa locquitor" theory. The court allowed the theory that such injuries do not happen in the absence of negligence despite evidence produced by the defense that dental injuries are a well-known risk of general anesthesia.

Prior to trial, the plaintiff attorney in this case had demanded $50,000 to settle. The anesthesiologist had previously made overtures to settle the case for up to $2,000 as a gesture of goodwill. On the eve of trial, after the majority of defense costs had already been incurred, plaintiff expressed a willingness to settle for $7,500. Typical of New York medical malpractice cases, this rather simple matter remained active for over seven years.

At the close of evidence, the plaintiff's attorney asked the jury to award $64,000, including up to $50,000 for past pain and suffering and additional amounts for future pain and suffering. The six-person jury returned a defense verdict on behalf of the anesthesiologist. The cost of defending this case was approximately $42,000. Pursuant to New York law, PPM was able to recover costs of only $750.

Robert Cavallo of White Plains, New York defended the case on behalf of the anesthesiologist. Pete Niosi, Claims Attorney, managed the file on behalf of PPM during the most recent years of litigation. ❖

Anesthesia & the Law *is published by*
Preferred Physicians Medical Risk Retention Group, Inc.
9000 West 67th Street, Shawnee Mission, KS 66202-3656
Telephone: 800-562-5589 Fax: 913-262-3633

Note: The purpose of this newsletter is to provide information to policyholders and defense counsel regarding professional liability issues. Risk management analysis is offered for general guidance and is not intended to establish a standard of care or to provide legal advice.

Newsletter Editor
Steven R. Sanford, JD
Vice President, Claims
Preferred Physicians Medical

As a convenience to our policyholders, the latest issue of Anesthesia & the Law is also available on the Preferred Physicians Medical website, www.ppmrrg.com. You may also visit the website for a brief overview of our operations or to find useful contact information.