ANESTHESIA & the LAW
A Risk Management Newsletter
DECEMBER 2012
ISSUE 35

PPM 25TH ANNIVERSARY

Wrongful Death: Missouri Defense Verdict

The case involved a 55 year-old female who presented to the emergency room with severe epistaxis (nosebleed) and hypertensive urgency. The patient was given an ASA IV-E classification due to her extensive list of co-morbidities, including but not limited to: obesity, diabetes, peripheral vascular disease, obstructive sleep apnea, coronary artery disease with right coronary artery angioplasty and stent, stroke and hypertension. The patient underwent nasal packing by an ENT surgeon and was transferred to ICU due to her multiple co-morbidities.

The patient's nose continued to bleed for three days; therefore, the ENT surgeon decided to perform endoscopic surgery to control the bleeding. Prior to surgery, the Preferred Physicians Medical (PPM) insured anesthesiologist planned for rapid sequence induction in response to the patient's hypertension, her recent meal and risk of aspiration. The general anesthetic and surgery proceeded without complication.

Upon completion of the surgery, the patient responded to commands, showed purposeful movement and demonstrated she could protect her own airway by coughing. Mindful of the patient's risk of renewed refractory bleeding, aspiration and obstructive sleep apnea, the PPM insured anesthesiologist reversed and extubated the patient in the operating room. The patient was then transferred from the surgical table to the bed. Upon transfer, the patient became asystolic and stopped breathing. CPR efforts were immediately initiated and the patient was re-intubated without incident and rhythm was restored.

The patient underwent a tracheostomy and was transferred to the ICU. The patient had a difficult course in the ICU including sepsis, self-extubations, re-intubations and encephalopathy. Approximately five weeks post-op, the patient was found in cardio-respiratory arrest with her tracheostomy tube displaced. The patient coded and was transferred to the ICU where she ultimately expired one week later. An autopsy revealed a primary diagnosis of coronary artery and hypertensive heart disease, followed by multiple secondary systematic organ failures.

The patient's family brought a wrongful death lawsuit against the PPM insured anesthesia group for the actions of its anesthesiologist. Plaintiffs relied upon the opinions and criticisms of a prolific plaintiff's anesthesiology expert, Dr. Brian McAlary, from Chicago, Illinois. During cross-examination, Dr. McAlary, did not dispute that his prior expert testimony had spanned 35 different states for a total of 354 cases for plaintiffs versus only 5 cases for defendants.

Plaintiffs' expert, Dr. McAlary, offered two primary criticisms about the PPM insured anesthesiologist's care: (1) premature extubation, and (2) failure to adequately monitor the patient. Dr. McAlary opined that these two issues contributed to a respiratory arrest that preceded a cardiac arrest.

Regarding the premature extubation allegation, Dr. McAlary conceded that no current medical publications corroborated the six extubation criteria he deemed were relevant to this patient. When read a testimonial excerpt of extubation criteria quoted from an 1989 premature extubation case, Dr. McAlary testified the "unidentified source" was "misinformed" and he "could not endorse" the statement because it made "no medical sense whatsoever." Dr. McAlary was then informed by PPM's defense attorney that the previously-unidentified source was, in fact, Dr. McAlary's own testimony from a case for which he had previously provided expert testimony.

Regarding the sequencing of the patient's cardio-respiratory arrest, Dr. McAlary also conceded that nothing in the record could irrefutably confirm the patient experienced respiratory arrest prior to cardiac arrest. Dr. McAlary conceded further that sudden cardiac arrest may occur even despite vigilant monitoring.

PPM's anesthesiology standard of care expert testified that PPM's insured anesthesiologist had "absolutely performed his duties correctly" and had appropriately managed the care of the "extremely difficult and extremely high-risk patient." The defense expert testified further that the patient's extubation was appropriate given her unique risks of prolonged intubation. The defense expert also explained that the medical record was replete with examples of cardiac arrest confirming his opinion that the patient had suffered a primary cardiac arrest prior to any respiratory failure. Further, based on the PPM insured anesthesiologist's testimony and the testimony of two

other surgical staff members who were present during the patient's cardiac arrest, the defense expert concluded that the operating room staff was "vigilant 100% of the time."

In closing statements, Plaintiffs' counsel requested that the jury "ignore the testimony of the experts" and suggested that any finding for the plaintiffs in an amount less than $500,000 would be "insulting." After deliberating for less than forty minutes, the jury reached a 12-0 unanimous verdict in favor of the PPM insured anesthesia defendants.

Gregory J. Minana, Esq. and Jordan Ault, Esq., with the law firm of Husch Blackwell, LLP in St. Louis, Missouri, represented PPM's insured anesthesia group and anesthesiologist. Brian J. Thomas, Senior Claims Attorney and Director of Risk Management, and Arik Worsfold, Claims Attorney, managed the file on behalf of PPM. ❖

IV Infiltration: Iowa Defense Verdict

The case involved a 48 year-old female with a history of a prior c-section who presented to the hospital at 35 weeks gestation in early labor for an attempted vaginal birth after cesarean section (VBAC). During the rupture of her membranes to allow placement of a fetal scalp probe, a prolapsed umbilical cord occurred. The patient was immediately transferred to the operating room for an emergency cesarean section (c-section). PPM's insured anesthesiologist provided general anesthesia for the c-section and a healthy infant was delivered.

Following the patient's return to her room, she was found to have intermittent hypotension. The patient did not want to have additional surgery so a CT scan of her abdomen was obtained to determine whether uterine artery embolization was an alternative. It was determined uterine artery embolization was not an alternative; therefore, the patient was returned to the operating room for an emergency laparotomy and hysterectomy. At that time, she had an IV in her left hand through which blood was being administered and an IV in her right hand through which medications were being administered.

PPM's insured anesthesiologist provided general anesthesia for the emergency laparotomy and hysterectomy. During the procedure there was no indication of any problem with the IVs. Immediately following the surgery, PPM's insured anesthesiologist noted the patient's right hand IV had infiltrated and appropriate consults were obtained. The initial consultants thought the patient's hand and arm would improve without surgical intervention. However, PPM's insured anesthesiologist was concerned the patient was developing compartment syndrome so he obtained an additional consultation. The patient subsequently underwent a fasciotomy, skin graft and carpal tunnel release.

The plaintiff filed a lawsuit against the obstetrician for failing to obtain hemostasis during the c-section and failing to timely diagnose a post-operative abdominal bleed resulting in the need to perform an emergency laparotomy and hysterectomy. PPM's insured anesthesiologist was also named as a defendant in the lawsuit. Plaintiff alleged the PPM insured anesthesiologist failed to appropriately monitor her IV resulting in infiltration and compartment syndrome.

Plaintiff made no settlement demand prior to trial. PPM's insured anesthesiologist felt strongly his care was appropriate and he was determined to defend his case. The case proceeded to trial against PPM's insured anesthesiologist and the obstetrician.

Plaintiff's anesthesiology expert was prolific plaintiff's expert, Joseph Stirt, M.D., of Charlottesville, Virginia, who testified the standard of care required the anesthesiologist to check the IV site every five minutes during the surgical procedure. To support his opinion, he stated that is why the Anesthesia Record is divided into five minute increments.

The defendant's anesthesiology expert testified that five minute checks of the IV site was not the standard of care and the monitoring provided by PPM's insured anesthesiologist was appropriate and did indeed meet the standard of care.

Following five days of testimony, the jury deliberated for approximately four hours before returning a unanimous verdict in favor of PPM's insured anesthesiologist and the obstetrician.

Robert Rouwenhorst, Esq., assisted by Ann Rouwenhorst, Esq., with the law firm Rouwenhorst & Rouwenhorst, PC in West Des Moines, Iowa tried the case. Shelley Strome, Senior Claims Specialist, managed the case and monitored the trial on behalf of PPM. ❖

Pain Management: Florida Defense Verdict

The lawsuit involved a 43 year-old female who presented for a cervical epidural steroid injection (CESI). The patient had a long history of right upper extremity, neck and lumbar pain that the PPM insured anesthesiologist had been treating for twelve years with medication, epidural steroid injections and stellate ganglion blocks. She was diagnosed with reflex sympathetic dystrophy approximately one year before the procedure at issue.

Monitored anesthesia care with sedation was administered by a CRNA who was supervised by an anesthesiologist, both of whom were not PPM insureds. The PPM insured anesthesiologist identified the C6-7 level with fluoroscopic guidance, and at approximately 2 cm to the right of midline, a #25 gauge needle was used to inject 2 ml of 1% lidocaine. A #20 Tuohy needle was advanced into the epidural space using the loss of resistance technique and no CSF, blood or paresthesia were noted. 6 ml of .05% marcaine with Depo-Medrol 80 mg was then injected. The patient appeared to tolerate the procedure well and was taken to the recovery room.

The patient became unresponsive, hypotensive and dusky shortly after arriving in the recovery room. ACLS protocol was initiated under the direction of the non-PPM insured anesthesiologist who successfully resuscitated the patient. Initially, she was unable to move her upper extremities. However, within less than an hour she could move all four extremities, but she was still experiencing some difficulty moving her right arm. The patient remained in the recovery room for two hours until she met discharge criteria. In a follow-up telephone call three days later, the patient reported her right arm was weak and she was unable to lift it, and her neck was very stiff.

Several days post-discharge, the patient continued to complain of increased right arm pain, weakness and numbness. She developed a peculiar occipital lesion at the back of her head, but not near or at the epidural site. The PPM insured anesthesiologist referred the patient to a neurologist and provided her a Medrol Dosepak.

Over the next several months, the patient experienced a complicated and puzzling course, including treatment for the occipital lesion and a small lesion near the site of the CESI injection. She had a brief admission at a hospital where a cervical MRI revealed changes that were thought to be consistent with an epidural abscess. However, all cultures were negative and her treating neurologist indicated she did not have an abscess as there were no signs of infection.

The patient also began experiencing very unusual symptoms with her right hand, losing fingernails on some of the fingers. Some of her fingertips became necrotic, and ultimately she underwent amputations of the fingertips (first joint) of three fingers and thumb of her right hand. Subsequent vascular studies revealed that she had some compromise of the circulation of her right hand, but the cause of the circulatory problems and necrosis of her fingertips was uncertain. She continued to complain of numbness and severe pain in her right arm. She also claimed of limited use of her right arm and hand.

The plaintiff sued the PPM insured anesthesiologist, the surgery center, the CRNA and the anesthesia group that employed the CRNA. Prior to trial, the surgery center and the non-PPM insured anesthesia group settled with the plaintiff for a confidential amount. With the PPM insured anesthesiologist's consent, PPM engaged in settlement negotiations with the plaintiff. However, given plaintiff's unreasonable settlement demand in the amount of $524,000 and the PPM insured anesthesiologist's resolve to defend his care, the case proceeded to trial.

Plaintiff's anesthesiology expert was prolific plaintiff's expert, William C. Berger, M.D., of Mill Valley, California. Dr. Berger testified that the PPM insured anesthesiologist deviated from the standard of care in performing the CESI by: 1) starting the injection 2 cm to the right of midline; 2) not utilizing two-plane fluoroscopy; 3) not utilizing contrast material and; 4) allowing the plaintiff to be overly-sedated. Dr. Berger testified these deviations from the standard of care caused "spinal cord shock."

The defense anesthesiology standard of care expert testified utilizing AP fluoroscopy to locate the correct level and loss of resistance technique met the standard of care. The defense expert also testified that no specific standard of care has been adopted for cervical injections and the technique utilized was reasonable. Finally, the defense expert testified that the plaintiff could not have sustained a spinal cord injury since there was no evidence of a dural puncture.

The PPM insured testified that the injection was completed without complication, and there was no evidence that he had punctured the dura. He also testified the plaintiff did not have spinal cord shock as she was moving all extremities post-operatively and met all discharge criteria.

Following a seven day trial, the jury returned a unanimous verdict after deliberating for approximately four hours.

The PPM insured anesthesiologist was represented by Gary Shipman, Esq. and Bill Whitney, Esq. from the law firm of Dunlap & Shipman, P.A. in Santa Rosa Beach, Florida. The file was managed on behalf of PPM by Tracey Dujakovich, Senior Claims Attorney. ❖

Risk Management Analysis

The prolific plaintiff experts identified in the cases above (Brian G. McAlary, MD, William C. Berger, MD and Joseph A. Stirt, MD) have combined to testify against their anesthesiology colleagues over 780 times and against PPM policyholders over 80 times.[1] In 2003, the American Society of Anesthesiologists (ASA) established Administrative Procedures and Guidelines for Expert Witness Qualifications and Testimony that allows the ASA to sanction ASA members whose expert testimony is found to fall outside the generally accepted practice standards and/or is inconsistent with relevant medical literature. Unfortunately, most prolific plaintiff experts never were or no longer are ASA members; thus, they are not subject to ASA oversight and possible sanctions. However, through the networking and sharing of information between PPM and our national panel of defense attorneys, PPM has been successful in attacking their credibility and trustworthiness using their own prior sworn testimony against them.

According to Arik Worsfold, Claims Attorney, "PPM's most recent successful defense verdict in Missouri included the impeachment of prolific plaintiff expert Dr. Brian McAlary in a manner normally reserved for television courtroom melodramas. During cross-examination, Dr. McAlary disparaged an excerpt of extubation criteria recited from an unidentified source, only to then learn that the excerpt had come from his own testimony in a 1989 premature extubation case. Dr. McAlary's only rebuttals to this revelation were that he "didn't remember the case" and that he could "hardly remember the '80s." I have no doubt that the jury immediately understood why an expert of Dr. McAlary's proclivities was utilized by the plaintiffs, and I believe the 12-0 unanimous defense verdict in favor of our policyholders reflected that."

Nerve Damage: New York Defense Verdict

The case involved a 72 year-old female who presented for a right total knee replacement. The anesthesia plan was to administer a spinal block and general anesthesia with a femoral nerve block for post-operative pain. The patient was provided informed consent for the spinal, general anesthesia and the femoral nerve block. The PPM insured anesthesiologist discussed the risks associated with the various anesthetic techniques, including the risk of nerve injury from the blocks. The informed consent form itself was a one-page document that indicated general anesthesia and "regional" anesthesia would be provided; however, the form did not specify the specific type of regional anesthesia.

The surgery was uneventful and the patient was taken to the PACU. The femoral nerve block was placed using a nerve stimulator approximately two hours later, after the patient had regained sensation in her legs. The patient was discharged from the PACU approximately three hours later with no complaints. The block continued infusing until it was removed on post-operative day two. The patient was discharged home with a leg brace. She had no complaints at that time regarding her right leg.

A physical therapist went to her house to perform physical therapy after the patient returned home. The physical therapist noted that the patient could not elevate her right leg while lying flat. The patient consulted her orthopedic surgeon who advised her that her recovery was going well. However, after several weeks, the therapist stated that further therapy would be unproductive and again advised the patient to speak with her orthopedic surgeon. An EMG indicated an injury to her femoral nerve that was causing weakness in her quadriceps muscle. The patient was referred to a neurologist and a subsequent EMG revealed injury to her femoral, peroneal and tibial nerves.

The plaintiff sued the PPM insured anesthesiologist alleging he failed to supply a proper informed consent regarding administration of the femoral nerve block. She also alleged that he never discussed the femoral nerve block with her and that she was not even aware she had received a femoral nerve block. The plaintiff alleged further that as a result of the PPM insured anesthesiologist's negligence, her femoral nerve was destroyed and she suffered total loss of the quadriceps muscle supporting the right knee and thigh.

Plaintiff demanded $1 million to settle the case prior to trial. The PPM insured anesthesiologist did not consent to settlement and no offer was made.

[1] Those figures were compiled by data from Total Expert Research On-Demand (formerly IDEX), a national clearinghouse for expert witness testimony, and PPM's electronic database initiated in 1999.

Plaintiff's anesthesiology expert was John Dombrowski, M.D., an anesthesiologist and pain management specialist from Washington, D.C. Dr. Dombrowski testified that the PPM insured anesthesiologist deviated from the standard of care by failing to provide the plaintiff adequate informed consent for the femoral block. He also testified that the informed consent form executed by the plaintiff failed to indicate that the plaintiff would be receiving a femoral nerve block and what risks regarding the nerve block were discussed with the plaintiff. Additionally, Dr. Dombrowski testified that the PPM insured anesthesiologist violated the standard of care by performing the nerve block in the PACU before the plaintiff had an opportunity to recover from the effects of spinal anesthesia. He opined that a femoral nerve injury resulted when the needle came in contact with the femoral nerve and the plaintiff was unable to react due to the lingering effects from the spinal anesthesia.

The defense anesthesiology standard of care expert testified that the plaintiff was given adequate informed consent. The executed form indicated that the patient was made aware that nerve injury is a risk of the procedure and, relying on the PPM insured anesthesiologist's custom and practice, the discussion with the patient regarding potential risks of the block was sufficient. Additionally, he testified that nerve injury during a femoral nerve block is a known and accepted complication of the block. He testified further that ultrasound was not standard of care in 2007 or even available at the facility where the surgery was performed. Finally, he testified that the second EMG supports an injury to the peroneal and tibial nerves, as well as the femoral nerve, which more likely suggests a tourniquet injury as opposed to one related to the femoral nerve block.

The jury also heard testimony from a nurse who conducted the "Total Joint Replacement Educational Class" the plaintiff attended prior to her surgery. The nurse testified that during the two-hour class, the plaintiff would have been provided an informational booklet and informed of the mechanics of the joint replacement procedure as well as the various forms of anesthesia the patient might receive, including general anesthesia, spinal block and femoral nerve block. At trial, the nurse presented the attendance sheet from the class and noted that the plaintiff was indeed an attendee. The plaintiff had previously testified that she attended the class and received the booklet, but stated that it was a 30 minute class where they were simply shown the joint replacement parts. The nurse's testimony was highly effective in casting doubt on the plaintiff's testimony that she had never heard of a femoral nerve block before her procedure.

The PPM insured anesthesiologist testified that the custom and practice at his hospital for total knee replacement procedures was for the patient to receive a femoral nerve block while in the PACU for post-operative pain management. He further testified that he discussed placement of the block and its risks, including nerve injury, with the patient during his pre-operative evaluation. She executed the consent and had no additional questions. He administered the block two hours after the patient had arrived in the PACU once the spinal began to wear off. During administration of the block, he utilized a nerve stimulator and noted no complications or complaints from the plaintiff. He was unaware of any complications she experienced until he was contacted by the plaintiff several weeks following the procedure.

Following a nine day trial, the six-person jury returned a unanimous defense verdict after deliberating for approximately five hours.

The PPM policyholder was represented by Michael E. Catalinotto, Sr., with the law firm Maynard, O'Connor, Smith & Catalinotto, LLP in Albany, New York. The file was managed on behalf of PPM by Tracey Dujakovich, Senior Claims Attorney. ❖

Risk Management Analysis

Informed consent remains an important element for not only reducing the likelihood of claims or litigation, but, as illustrated in case above, defending anesthesiologists in the courtroom. "Even though the informed consent form was lacking in detail regarding the specific anesthetic techniques and significant risks of a nerve block, the testimony from the PPM insured anesthesiologist and the nurse who conducted the pre-surgery class provided the jury with compelling evidence that the plaintiff was informed she was going to receive a femoral block and about the risk of nerve injury," according to Tracey Dujakovich, Senior Claims Attorney.

PPM continues to strongly advocate the use of a standardized anesthesia-specific informed consent that identifies all of the significant risks of anesthesia and provides some specific information regarding the available anesthetic choices. PPM's Claims Attorneys and Specialists are available to assist your anesthesia practice in developing and implementing an anesthesia-specific informed consent tailored to meet your practice needs and environment. PPM policyholders may also access and download PPM's recommended informed consent forms by visiting ppmrrg.com and clicking the My PPMrrg tab for PPM's secure area exclusively for PPM policyholders.

PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP, INC.
9000 West 67th Street
Shawnee Mission, KS 66202-3656

T 913.262.2585 • 800.562.5589
F 913.262.3633

NEWSLETTER EDITOR
Brian J. Thomas, JD
Senior Claims Attorney
Director of Risk Management

ANESTHESIA & the LAW
A Risk Management Newsletter
DECEMBER 2012
ISSUE 35

In This Issue

Over the past 25 years, Preferred Physicians Medical has continued its commitment to aggressively defend our policyholders. While most of our policyholder's cases are successfully resolved before reaching trial, Preferred Physicians Medical's policyholders win over 85 percent of all cases taken to trial.

In addition to Preferred Physicians Medical's record of 42 consecutive defense verdicts with 0 plaintiff's verdicts in defending upper extremity nerve damage claims, Preferred Physicians Medical achieved another milestone this year - securing three unanimous defense verdicts for Preferred Physicians Medical policyholders in three different states in the same week.

In this issue, we highlight several of our most recent cases and offer some risk management analysis.

Thanks for reading,

Brian J. Thomas, Editor

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.