ANESTHESIA & the LAW
A Risk Management Newsletter
APRIL 2014 – ISSUE 38

PPM Secures 43rd Consecutive Defense Verdict in Upper Extremity Nerve Damage Litigation

Since 1998, PPM has aggressively defended upper extremity nerve damage cases related to positioning. In the Company's early years, PPM noted most upper extremity nerve damage litigation – ulnar and brachial plexus neuropathies attributed to improper padding and positioning – was routinely settled by malpractice insurance companies for amounts ranging from $150,000 to $200,000. According to Wade Willard, PPM's Vice President for Claims, the Company studied this litigation, reviewed available medical literature and consulted with prominent anesthesia experts. Based on this analysis, PPM concluded most upper extremity nerve damage cases were entirely defensible and embarked on an assertive trial strategy. Although it required considerable effort to reshape defense counsel's predisposition to recommend settlement, PPM has now established an impressive trial record defending these cases; 43 defense verdicts, 0 plaintiff verdicts . In addition to courtroom victories, plaintiffs in a number of other upper extremity nerve damage cases have voluntarily dismissed litigation upon learning of PPM's successful trial record.

PPM's latest upper extremity nerve damage case involved a 38 year-old male who underwent a right nephrectomy. Prior to the procedure, an epidural was administered for post-operative pain. The patient was placed in the left lateral decubitus position with an axillary roll and with arm boards and gel padding at his heels, arms and feet. The procedure was completed in approximately 41 minutes without apparent complications. The patient was received in PACU in stable condition and later transferred to his hospital room. During a six day hospital stay, the patient's only recorded complaint was thigh paresthesia two days post-operatively. At discharge, no complaints were noted. Approximately two weeks after discharge, the patient complained to his surgeon regarding numbness in his "pinky and ring finger" of his left hand extending to the lateral portion of the palm. The patient was referred to a neurologist and diagnosed with an ulnar neuropathy.

The patient sued the PPM insured anesthesia group, as the anesthesiologist's employer, and the hospital. The patient alleged his injury was caused by improper positioning, padding and monitoring of his arm during the surgical procedure. The patient also claimed the ulnar nerve injury and permanent damage to his left hand caused his total disability.

During his deposition, the patient testified he immediately noticed numbness and tingling in his left arm upon awakening from surgery. He testified he informed the surgeon of numbness and tingling a couple of days later, but not the nursing staff. According to the patient, he was under the effects of pain medication for several days following the surgery and was unable to report his symptoms immediately. In contrast to this testimony, the medical records during his hospitalization noted that he was awake, alert and did not include any notes regarding upper extremity complaints.

Prior to trial, the patient made a global settlement demand in the amount of $139,000. In consultation with PPM and defense counsel, PPM's insured anesthesia group declined to consent to settlement. The hospital offered a nominal settlement that was rejected.

The case proceeded to trial with Miles Dinner, MD, from New York, New York, serving as the patient's anesthesiology expert. Dr. Dinner's opinion was dependent on the patient's testimony that he had symptoms immediately after the surgery, even though the medical record was absent any notes regarding any upper extremity complaints. Dr. Dinner suggested the thigh paresthesia noted in the chart was misattributed and was related to the patient's arm. Dr. Dinner ultimately conceded there was nothing in the chart to indicate anything was done improperly by either the anesthesiologist or the nurses, but testified that the standard of care requires position checks to be performed and documented every 15-20 minutes. Dr. Dinner opined that the anesthesiologist and nurses who attended to the patient during his surgery breached the standard of care and the fact an ulnar neuropathy occurred confirmed there was negligence.

PPM's insured anesthesiologist testified that the patient was appropriately positioned, padded and monitored during the short procedure. He also testified that the documentation regarding positioning was contained in the nursing and anesthesia notes.

The defense anesthesia expert testified there was no evidence in the medical record that the patient suffered an ulnar nerve injury during his six day hospitalization. He also testified that the medical record contained sufficient documentation to demonstrate the patient was appropriately positioned, padded and monitored. The defense expert testified further that, in his opinion, it was more likely the patient sustained this injury following his discharge from the hospital.

After a six day trial, the jury deliberated for approximately three and a half hours before returning a unanimous defense verdict for PPM's insured anesthesia group and a 7-2 defense verdict for the hospital.

Elizabeth Germani, Esq., with the law firm Germani, Martemucci, Riggle & Hill, in Portland, Maine, tried the case on behalf of PPM's insured anesthesia group. Shelley Strome, Senior Claims Specialist, managed the file on behalf of PPM. ❖

Cardiac Arrest: Arizona Defense Verdict

This case involved a 63 year-old female, ASA 3, with a medical history significant for smoking a pack a day for 40 years, obesity, hypertension and complaint of right upper quadrant abdominal pain. An ultrasound showed gallstones and cholecystitis. The patient underwent a laparoscopic cholecystectomy with general anesthesia administered by a PPM insured anesthesiologist.

Normal blood pressure readings were obtained from the time of induction until just after the surgery began. Approximately fifteen minutes into the surgery the anesthesiologist noticed a low systolic blood pressure in the 50s-60s that was immediately treated with a dose of Neo-Synephrine. When the blood pressure did not improve, a second dose of Neo-Synephrine was administered without improvement. In response, the anesthesiologist exposed the patient's arm that was draped and discovered the blood pressure cuff was wide open on the table and trapped beneath the patient's arm. The anesthesiologist re-applied the cuff and determined the patient's blood pressure was approximately 200/108. He immediately treated the high blood pressure with Propofol. The blood pressure returned to a normal range and every blood pressure reading throughout the surgery remained within a normal range.

The patient was taken to PACU where she was noted to be hypoxic upon extubation. Because the anesthesiologist had started the next case, several other physicians became involved in the patient's care to determine and address the cause of her ongoing hypoxia. A cardiac enzyme test confirmed the patient experienced a myocardial infarction, though the timing of the heart attack was not determined.

The anesthesiologist acknowledged he did not record the low or the high systolic blood pressures or the Neo-Synephrine dosages on the Anesthesia Record. He also did not immediately inform the surgeon regarding the misapplied blood pressure cuff and resulting treatment. After the heart attack was confirmed, the anesthesiologist did inform the physicians caring for her about the hypotensive episode experienced during surgery. Several hours after the surgery, he also drafted a detailed Progress Note regarding these events.

Four days after the initial surgery, the patient underwent a coronary artery bypass with full recovery.

The patient and her husband sued the PPM insured anesthesiologist alleging the anesthesiologist was negligent for failing to ensure the blood pressure cuff was properly affixed to the patient's arm prior to and during surgery. The patient also alleged he negligently administered unnecessary Neo-Synephrine that caused the heart attack. Further, the patient alleged the anesthesiologist didn't contemporaneously record the blood pressure readings or the administration of the two doses of Neo-Synephrine in order to cover-up the negligence that had occurred.

The patient made a $321,800 settlement demand prior to trial. The PPM insured anesthesiologist, in consultation with defense counsel and PPM, declined to consent to settlement and the case proceeded to trial.

The patient's standard of care expert was Joseph A. Stirt, MD, an anesthesiologist from Charlottesville, Virginia. Dr. Stirt – who has testified against anesthesiologists approximately 60 times in his career – testified that the PPM insured anesthesiologist fell below the standard of care by not confirming the patient's low blood pressure prior to

administering Neo-Synephrine. According to Dr. Stirt, the standard of care requires checking the patient's carotid artery, radial artery, the blood pressure cuff, and the tubing to the cuff, before administering a vasopressor. He also testified that the anesthesiologist's failure to document the hypotensive event or tell others about it until later in the afternoon was not just a breach of the standard of care, but was borderline reckless.

The patient's causation and damages expert, Richard Spellberg, MD, from Lakewood, California, testified that the anesthesiologist's administration of Neo-Synephrine caused the patient to suffer an intra-operative heart attack, which in turn caused her to need a coronary artery bypass. According to Dr. Spellberg, had patient not had the heart attack, she most likely would have lived out her days symptom free and blissfully unaware that she had severe coronary artery disease. His basis for that opinion was that the disease had not manifested itself by the time of the gall bladder surgery and so was unlikely to ever do so. He also testified that smoking, even smoking a pack a day for forty years, was only a minor risk factor in the development of heart disease or heart attacks.

PPM's standard of care expert testified that in the face of life-threatening hypotension in the 50-60 systolic range, the most appropriate action is to swiftly treat it, especially in light of the fact that the blood pressure cuff was admittedly working correctly for the first 15-20 minutes of the surgery and there was nothing on the monitors to indicate the hypotension was a false reading (i.e. the reading was neither "0" nor an error message). Therefore, in his opinion, the anesthesiologist was not required to check the machine or check for a pulse prior to treatment. He also noted that pulse oximetry was indicating the patient had a normal pulse.

PPM's causation expert testified that more probable than not, patient's heart attack started prior to surgery and manifested itself during surgery in the form of sudden onset hypotension. The anesthesiologist's treatment of that hypotension with Neo-Synephrine most likely saved her life. He based his opinion on the troponin level, which was already decreasing by the time of the report. A decreasing level of troponin suggests the heart attack had already peaked and was beginning to subside by the time they drew the patient's blood for analysis at 11:00 a.m. And since that process takes at least 4-6 hours to occur, the heart attack must have started between 5:00 a.m. to 7:00 a.m., before the surgery started at approximately 7:56 a.m. This defense expert further testified that if the blood pressure cuff had been loose at the time of the low reading, it would have given a false high reading instead of a false low reading. Thus, the reading was either correct (since there was no "0" or error message) or it was even lower than 50-60 shown on the monitor.

During closing arguments, the patient's attorney argued that the anesthesiologist's actions were far below the standard of care and amounted to an attempted cover up. The patient's attorney said they were asking for an award of $600,000, even though that amount was not nearly enough to compensate his clients for their pain and suffering.

The jury deliberated for approximately one and a half hours before returning a unanimous defense verdict. PPM was awarded a $20,356.29 cost judgment against the patient.

The PPM policyholder was represented by Charles E. Trullinger, Esq. and Russell Wenk, Esq. with the law firm Trullinger & Wenk, PLLC in Goodyear, Arizona. The file was managed on behalf of PPM by Shelley Strome, Senior Claims Specialist, and Brian J. Thomas, Senior Claims Attorney & Director of Risk Management. ❖

Risk Management Analysis

Following the above-referenced defense verdict, seven of the ten jurors agreed to discuss the trial with defense counsel. The jurors believed the anesthesiologist's charting at the time of the events was inadequate, but that he nevertheless met the standard of care in treating the patient. From a risk management perspective, charting the events contemporaneously or near the time of the incident might have deterred the patient from filing a lawsuit. Plaintiff attorneys are notorious for attempting to distort the facts and evidence to create the perception of a conspiracy, fraud and/or cover-up. Poor documentation, alterations and/or late entries in the medical record encourage plaintiff attorneys to file litigation. Plaintiff attorneys routinely use charting deficiencies and conspiracy theories to divert the jury's attention from important medical facts. According to Shelley Strome, Senior Claims Specialist, "Accurate medical records not only promote quality patient care, they also discourage plaintiff attorneys from filing litigation in cases where the medicine is defensible."

Cardiac Arrest Following Colonoscopy: New Jersey Defense Verdict

The case involved a 55 year-old male who presented for an elective colonoscopy to rule out ulcerative colitis. The patient's medical history was significant for diverticulosis of the colon, cardiac dysrhythmia, diabetes mellitus, insulin dependence, hypertension, chronic non-alcoholic liver disease, and cardiomegaly. Two months prior to this procedure the patient underwent cardiac testing. An echocardiogram showed mild tricuspid valve regurgitation with normal cardiac ejection fraction. An exercise screening test for coronary arterial disease showed good exercise capacity with no significant ST changes. The patient had previously undergone a colonoscopy and had no difficulties with anesthesia.

The patient was transferred to the endoscopy suite at 11:45 a.m. The PPM insured anesthesiologist understood the patient was being treated for a cardiac arrhythmia, but elected not to run a 12-lead EKG because the patient presented with no cardiac symptoms and his pre-procedure 3-lead rhythm strip showed no significant abnormalities. The patient was designated ASA 3 based upon his co-morbidities. The anesthesia plan was for monitored anesthesia care (MAC) with intravenous conscious sedation. At the start of the case, the patient's blood pressure was 120/70, heart rate at 78 and respirations at 16. The patient was administered IV sedation with 100 mg of Propofol. As the scope reached the cecum, the patient experienced an episode of bradycardia and intravenous atropine was administered. The patient's heart rate responded to the atropine and increased to approximately 65-70 bpm. The PPM insured anesthesiologist advised the gastroenterologist to complete the procedure, which was finished within three minutes.

At the conclusion of the procedure, the patient was awakening with stable hemodynamics while preparations were made to transfer him to the PACU. However, while the patient was still connected to the monitors, the anesthesiologist noted his heart rate fell to 40 bpm and SpO2 declined to 78% and then 62%. The anesthesiologist administered atropine 1.0 mg IV and commenced Ambu mask ventilation with 100% oxygen, raising the SpO2 to 85% and the heart rate to 78 bpm. The positive response was short-lived and asystole ensued. A Code Blue was called at 12:15 p.m. and the anesthesiologist promptly intubated the patient while the circulating nurse began closed chest compressions. Resuscitative efforts continued; however, the patient remained pulseless until the code was called and the patient was pronounced dead at 1:02 p.m.

The significant findings on autopsy included atherosclerosis with 85% occlusion of the left anterior descending coronary artery and 95% occlusion of the right coronary artery, acute biventricular heart failure, hepatomegaly with marked congestion of the liver and mild cardiomegaly with hypertrophy of the left ventricle. Gross examination of the heart lacked evidence of ischemic changes or infarction. Microscopic examination of the heart showed only rare foci of interstitial mild fibrosis. No myocardial infarction was noted. Other possible causes of death included cardiac dysrhythmia or some transient conduction abnormality possibly brought on by a metabolic derangement.

The patient's wife filed a lawsuit against the PPM insured anesthesiologist alleging he should have obtained a 12-lead EKG before proceeding with sedation because the pre-procedure 3-lead rhythm strip displayed abnormalities.

No settlement demands were made prior to trial and the PPM insured anesthesiologist, in consultation with PPM and defense counsel, did not consent to settlement and the case proceeded to trial.

The patient's anesthesiology expert was Lorne Sheren, MD, from Fairmont, West Virginia. Dr. Sheren's primary criticism was that the pre-procedure 3-lead rhythm strip demonstrated ST segment elevations that required the procedure to be delayed and a 12-lead rhythm strip be obtained. Dr. Sheren, however, made several concessions including that the PPM insured anesthesiologist promptly and effectively treated the bradycardia; that it was appropriate for the gastroenterologist to complete the procedure given that the gastroenterologist had already advanced the scope to the cecum; and that the resuscitative measures taken after the patient's cardiac arrest were handled appropriately.

The patient also presented cardiology expert, Bruce Charash, MD, from New York, New York. Dr. Charash was also of the opinion that the pre-procedure 3-lead rhythm strip demonstrated an abnormality. Contrary to the opinion of Dr. Sheren, Dr. Charash testified that the pre-procedure rhythm strip demonstrated a 2:1 AV block, not an ST segment elevation. Nevertheless, he too believed the procedure should have been cancelled and a 12-lead

EKG should have been obtained to investigate the abnormality. Dr. Charash testified there was a hidden P wave occurring inside the T wave following the QRS complex. He testified further that the patient suffered a complete heart block during the initial episode of bradycardia, which later contributed to the second attack that did not respond to atropine.

PPM's anesthesiology expert testified that because the patient's extensive cardiac work-up had been negative and the patient denied cardiac symptoms, the standard of care did not require any different monitoring, anesthetic medications, or precautions than those employed. He further testified that the pre-procedure rhythm strip demonstrated a normal sinus rhythm showing no evidence of either ST segment elevations or a 2:1 AV heart block.

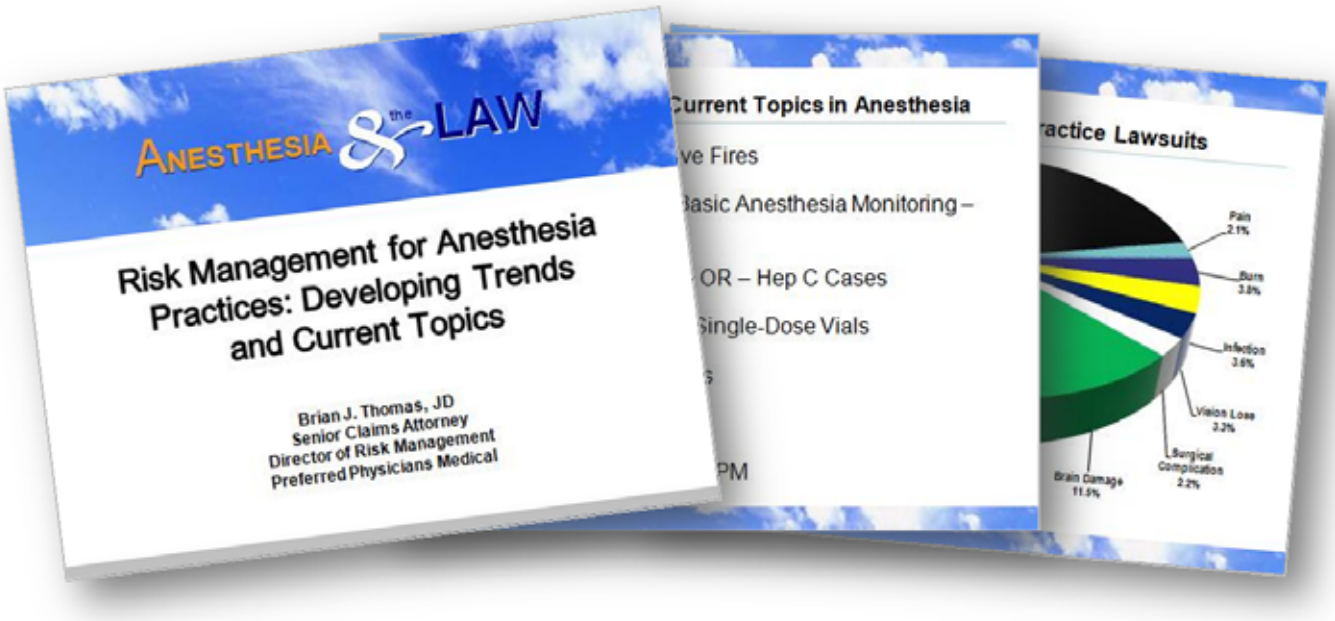
PPM's cardiology expert testified that the rhythm strip showed a normal rhythm and required no follow-up with a 12-lead EKG. He strongly disagreed with Dr. Charash's interpretation of the rhythm strip. It was his opinion that the stress test two months prior likely reported a false negative; however, it was within the standard of care for the PPM insured anesthesiologist to rely on the records available to him and the patient's clinical presentation on the day of the procedure. As to cause of death, he believed that the combination of the second episode of bradycardia and the decedent's severe coronary artery disease caused a fatal arrhythmia. As the patient's right coronary artery was 95% blocked, the patient's bradycardia further reduced the already compromised blood flow to the sinus node leading to asystole and death.

Following an eight-day trial, the jury returned a unanimous defense verdict after deliberating for approximately one and a half hours.

The PPM policyholder was represented by Bruce Brady, Esq. with the law firm of Callan, Koster, Brady & Brennan, LLP in New York, New York. The file was managed on behalf of PPM by Tracey Dujakovich, Senior Claims Attorney. ❖

PPM's Risk Management Highlights Anesthesia Expertise

PPM develops its risk management materials using information gathered from our investigation of over 12,150 adverse anesthesia events. Utilizing this substantial database, PPM monitors developing anesthesia loss trends, identifies areas of increased risk, and provides practical, anesthesia-specific risk management advice and strategies. Since 2002, PPM has conducted over 292 on-site, anesthesia-specific risk management seminars for PPM insured anesthesia practice groups and policyholders. According to Brian Thomas, Director of Risk Management, "PPM's on-site risk management programs address very specific anesthesia practice concerns that are tailored to our policyholder groups. When a PPM policyholder tells us, 'I changed my practice after coming to one of your seminars,' there is no stronger evidence that our risk management efforts are improving patient safety and reducing our policyholders' liability and claims." ❖



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

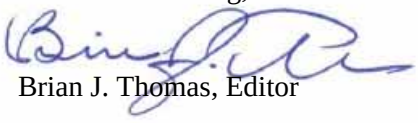
ANESTHESIA & the LAW
A Risk Management Newsletter
APRIL 2014 – ISSUE 38

In This Issue

In 2013, Preferred Physicians Medical continued its commitment to aggressively defend our policyholders. In this issue we highlight some of our recent successes in the courtroom, including securing Preferred Physicians Medical's 43rd consecutive defense verdict in upper extremity nerve damage litigation.

- PPM Secures 43rd Consecutive Defense Verdict in Upper Extremity Nerve Damage Litigation
- Cardiac Arrest: Arizona Defense Verdict
- Cardiac Arrest Following Colonoscopy: New Jersey Defense Verdict
- PPM's Risk Management Highlights Anesthesia Expertise

Thanks for reading,



Brian J. Thomas, Editor