ANESTHESIA & the LAW
A Risk Management Newsletter
MARCH 2018 – ISSUE 45
PPM

Catch Me If You Can: Patient Falls in the Anesthesia Workplace

Defending Patient Falls Litigation

As members of the surgical care team involved in positioning, monitoring and transferring patients, anesthesia providers have an important role and share in the duty to keep patients safe from falls. Patients, families and juries are unlikely to accept that patient falls are a known risk and complication. In most cases, these adverse events result in litigation against the anesthesia providers and other team members present. Defending litigation involving patient falls is extremely challenging for multiple reasons and frequently results in settlements, as highlighted by the following case studies.

Case #1

A 20-year-old female was receiving epidural steroid injections for low back pain and sciatica. The PPM insured anesthesiologist started an epidural steroid injection without the assistance of a nurse or other healthcare assistant. The local anesthesia was administered without any issues. As the epidural needle was placed, the patient fainted and fell from the procedure table onto the floor, landing on her face and shoulder. The patient sustained lacerations to her face and bruises to her lips. The patient was examined; no fractures were found on x-ray and she was referred to a plastic surgeon. The patient underwent a laminectomy two months after the incident.

The patient sued the anesthesiologist and hospital. She alleged negligent performance of an epidural steroid injection in failing to position someone in front of her resulting in her fall. She further alleged she suffered a head injury with continuing headaches, facial scar and exacerbation of her pre-existing back condition that required a laminectomy. Finally, the patient claimed she had to take a semester off from college due to her pain and subsequent surgery resulting in additional tuition costs. The patient's initial settlement demand was $150,000.

During discovery, the defense obtained the patient's academic records that showed she had been placed on academic probation for two semesters for failing grades prior to the injury in question. The patient appeared at her deposition with no obvious scars or physical limitations. She testified she was not receiving any ongoing medical treatment or therapy since her laminectomy.

The defense expert testified he could not support performing an epidural steroid injection without the assistance of a nurse. He did, however, opine the way the patient fell face down would not have exacerbated her low back condition. He indicated the patient's low back condition was steadily deteriorating and she would have needed a laminectomy regardless of the fall. The patient's medical records also confirmed she had reported a history of headaches prior to the fall.

In This Issue

Hundreds of thousands of patient falls occur in hospitals in the United States every year with an estimated 30-50 percent resulting in injury.[1] Patient falls in the anesthesia workplace are less frequent but continue to cause serious patient harm, including brain damage and death.[2,3] Patient falls frequently result in litigation, medical and nursing board investigations and other significant consequences. In this issue, we examine these relatively rare but preventable adverse events, highlight two case studies and offer risk management analysis and strategies to prevent patient falls in the anesthesia workplace. PPM also reports our 44th consecutive defense verdict in upper extremity nerve damage litigation. In the Underwriter's Spotlight, we announce PPM's Cyber Liability Insurance standard coverage has been increased from $50,000 to $100,000 limits for PPM policyholders at no additional charge.

Thanks for reading.

Brian J. Thomas, Editor

The hospital was dismissed prior to trial. Despite several rounds of negotiations, a mutually agreeable settlement amount could not be reached and the parties proceeded to trial. On cross-examination, defense counsel questioned the patient regarding her significant medical history of back pain and her academic challenges prior to the fall. Based on her testimony and concessions, her attorney lowered the settlement demand and the case settled for $35,000 in indemnity with $33,327 incurred defense costs (loss adjustment expense – LAE).

Risk Management Analysis

The hospital policy for epidural steroid injections required the presence of a nurse or other healthcare assistant before the procedure could begin. The violation of the hospital policy and the resulting fall was a deviation from the standard of care. Additionally, the anesthesiologist admitted he made a mistake and apologized to the patient following this incident. Based on these facts, the defense admitted liability and tried this case only on damages. While not a common defense strategy, this prevented the patient's attorney from attacking the anesthesiologist's credibility and allowed the defense to challenge the patient's damages claims.

Case #2

A 50-year-old morbidly obese female presented for left shoulder surgery. Following an incomplete interscalene block, the PPM insured anesthesiologist converted to general anesthesia. The initial administration of propofol was inadequate, so he turned to obtain another syringe. While turned away from the patient, he heard a loud noise. He turned around to discover the patient had fallen onto the floor. He quickly ensured adequate ventilation and performed a physical examination. In the weeks following the surgery, the patient complained of pain in her left elbow, neck and right shoulder. She subsequently underwent surgery on her right shoulder and left elbow.

The patient and her husband sued the anesthesiologist and hospital. The patient alleged the anesthesiologist breached the standard of care by failing to properly supervise the immobilization of his patient. The patient alleged the hospital's nursing staff was negligent for failing to strap the patient to the O.R. table. The patient alleged both the anesthesiologist and the hospital were negligent for allowing the patient to fall off the O.R. table onto the floor.

During her deposition, the patient testified that before her injuries she was the primary caretaker who did everything around the couple's home, including yardwork and household tasks. The patient testified further that despite her subsequent right shoulder and left elbow surgeries she still suffered from significant pain that prevented her from doing most, if not all, of the things she did prior to her original surgery. The patient also testified the anesthesiologist made several follow-up calls to their home and admitted her fall was his fault and he was negligent.

The defense took the deposition of the patient's treating physician who performed her shoulder and elbow surgeries. The treating physician testified that following her shoulder surgery her recovery was excellent and she had regained 80% function of the right shoulder. Following the surgery on the patient's left elbow, he noted her recovery was again excellent with almost full return of function. Three months after her last surgery, he released the patient to full activities without any restrictions.

Based on the contradictory deposition testimony between the patient and her treating physician, the defense obtained surveillance of the patient. Video surveillance revealed the patient engaged in activities inconsistent with her deposition testimony. She was observed on multiple occasions opening and shutting doors, and lifting and carrying grocery bags with both hands without any apparent restriction or limitations.

All parties agreed to participate in mediation prior to trial. The patient's initial settlement demand was $350,000. The defense showed the surveillance video that clearly refuted the patient's claims of disability and limitations. The patient's attorney then lowered her demand and the case settled on behalf of the PPM insured anesthesiologist for $70,000 in indemnity with $19,558 LAE. The hospital settled with the patient for a confidential amount.

Risk Management Analysis

The PPM insured anesthesiologist acknowledged in his deposition he had an important role to ensure the patient's safety in the O.R. However, he testified he was unaware the nursing staff had not placed the strap to secure the patient to the O.R. table. He also confirmed he did speak with the patient after the incident, apologized and stated she should not have fallen from the O.R. table. However, he denied telling the patient he or anyone else on the surgical team was negligent.

This litigation was filed in a state that had enacted a statute that prohibits certain statements, expressions or other evidence related to disclosure of an adverse event from being admissible in a lawsuit. These statutes are commonly referred to as "apology laws" and typically provide immunity to health care providers for expressions of empathy or sympathy following an adverse medical event.[4] Therefore, if this case had proceeded to trial, the anesthesiologist's apology would not have been admissible to prove he was negligent, according to Shelley Strome, PPM's Senior Claims Specialist.

Legal Considerations

Like nearly all "never" events, patient falls in the anesthesia workplace are considered preventable.[5]

Plaintiff attorneys typically argue preventing patient falls is a shared responsibility and each member of the surgical care team has a duty to prevent these potentially devastating and life-threatening complications. Litigation involving patient injuries from falls also allows plaintiff attorneys to argue "res ipsa loquitur" (Latin for "the thing speaks for itself"), which is the legal doctrine that infers negligence from the very nature of the injury and allows plaintiffs to meet their burden of proof without the need for expert testimony.[6] In most cases, jurors simply will not accept that these types of accidents and resulting injuries occur without negligence.

Given these defense challenges, plaintiff attorneys typically evaluate these cases as having increased settlement value, even when the injuries may not be severe. Based on the uncertainty of allowing a jury to calculate the amount of damages to be awarded to a patient who is injured from an arguably preventable fall, most anesthesia providers and their professional liability carriers settle these cases rather than defend them at trial.

Legal and other consequences of these settlements may include:

- National Practitioner Data Bank reporting
- State medical licensing board investigations and sanctions including fines, published reprimands, and mandatory continuing medical education and training
- Centers for Medicare and Medicaid Services and third-party payer investigations and disciplinary actions
- Suspension and non-renewal of privileges at practice facilities
- Significant negative media coverage

Causes of Patient Falls

There are a number of key elements that have been identified as contributing to patient falls in the anesthesia workplace:

- Patient attributes – obesity, age, lateral positioning, sedated or altered consciousness, and agitation during induction or emergence
- Provider actions and inactions – distractions, shifting attention from patient to other unrelated O.R. tasks, assumption that other providers are securing the patient, and vulnerability to production pressure

- O.R. table factors – new or unfamiliar O.R. tables and controls, improper function or use of locking mechanism on Jackson spinal table or other mechanical table failures, extremes in positioning (e.g. side tilt, steep or reverse Trendelenburg position)
- Absence or inadequacy of safety restraints
- Table tipping

Risk Management Recommendations

Anesthesia providers, as patient safety advocates, should help focus perioperative team attention to three primary contributors to minimize the risk of patient falls:

1. Familiarity with the controls, operations and the safe weight limits of all O.R. tables used in their facility; or have ready access to such information or to knowledgeable personnel
2. Coordination of all patient movements/transfers – sudden and expected transfers of obese patients may be difficult to stop once initiated
3. Entire perioperative team should understand their specific roles and proactively discuss patient observation responsibilities for all phases of intraoperative and near-perioperative periods

PPM Secures 44th Consecutive Upper Extremity Nerve Damage Verdict

Since 1998, PPM has aggressively defended upper extremity nerve damage cases related to positioning. PPM continues an impressive trial record defending these cases: 44 defense verdicts, 0 plaintiff verdicts. In addition to courtroom victories, plaintiffs have voluntarily dismissed litigation in a number of other upper extremity nerve damage cases upon learning of PPM's successful trial record.

PPM's latest upper extremity nerve damage case involved a 59-year-old male who underwent a coronary artery bypass graft (CABG X 4). The patient was positioned supine. His arms were wrapped in gel pads and tucked with his palms to his thighs by the nursing staff. Following the surgery the patient was taken to recovery and then transferred to ICU.

On the morning of the first post-operative day the patient complained of numbness in the 4th and 5th fingers of his right hand. EMG testing approximately six weeks later diagnosed a lesion across the elbow at the cubital tunnel. The patient underwent cold laser therapy provided by a chiropractor and was released to return to work approximately three months following his surgery.

Two months later the patient reported to his chiropractor that he had fallen asleep with his arm bent at the elbow and re-injured his ulnar nerve. Over the next several years he underwent a carpal tunnel release and several surgeries on his right hand. The patient attributed all subsequent surgeries to his ulnar nerve injury.

The patient filed a lawsuit naming the surgeon, PPM's insured anesthesiologist and hospital as defendants alleging partial paralysis in his right arm as a result of improper positioning or padding of his arm, or allowing his arm to fall off the operating room table. The surgeon was subsequently dismissed from the lawsuit.

Prior to trial the patient made a $350,000 demand to the anesthesiologist who was determined to defend his care. The case proceeded to trial against the anesthesiologist and hospital.

The patient's anesthesiology expert from St. Elizabeth's Medical Center, Brighton, MA testified an ulnar nerve injury would not have occurred if reasonable care had been provided by the anesthesiologist. He testified further the anesthesiologist can ensure no ulnar nerve injury occurs by making certain the patient is padded and

positioned appropriately. Finally, he also testified if the anesthesiologist had appropriately supervised the nurses the injury would not have occurred.

The defense anesthesiology expert testified that ulnar nerve injuries can, and do, occur in cases where everything is done correctly. There was no information in the medical record to indicate the patient was padded or positioned inappropriately. The defense expert testified the standard of care was met and the patient's injury had resolved, as demonstrated on EMG studies.

Following an eight-day jury trial, the judge granted a directed verdict in favor of PPM's insured anesthesiologist ruling the patient failed to prove his case. The judge made her ruling because although the patient's expert testified the injury occurred because of negligence, he had no opinion as to what the anesthesiologist should have done differently to prevent the injury. The jury returned a defense verdict in favor of the hospital.

Gary Fadell, Esq., Fadell Cheney & Burt, PLLC, Phoenix, AZ tried the case. Shelley Strome, Senior Claims Specialist, managed the case on behalf of PPM.

Underwriter's Spotlight

PPM Cyber Liability Insurance Coverage Limits Increased

In response to the increasing risk of cyber-attack[7], effective January 1, 2018, PPM's Cyber Liability (eMD™) Insurance standard coverage has been increased from $50,000 to $100,000 limits for PPM policyholders at no additional charge. No underwriting is required and no deductible applies.

According to John Morhiser, PPM's Underwriting Supervisor, "the increase in limits of this important coverage is being extended through a partnership with NAS Insurance, the leading provider of Cyber Liability Insurance to health care professionals in the United States."

PPM's website, ppmrrg.com, also provides useful cyber liability risk management resources via its partnership with NAS Insurance. For more information, please contact your PPM sales or underwriting representative.

References:

1. The Joint Commission. Sentinel Event Alert 55: Preventing falls and fall related injuries in health care facilities, Issue 55, September 28, 2015. Available at: https://www.jointcommission.org/sea_issue_55/ (accessed 03/12/2018).
2. A search of PPM's database of 14,159 adverse anesthesia events identified 129 patient falls including 37 claims and litigation files.
3. Prielipp RC, Weinkauf JL, Esser TM, Warner MA, Thomas BJ. (September 2017). Falls from O.R. or Procedure Table. *Anesthesia & Analgesia*. Retrieved from https://journals.lww.com/anesthesia-analgesia/Citation/2017/09000/Falls_From_the_O_R__or_Procedure_Table.22.aspx
4. Apology Laws – Sorry Works! Available at: http://sorryworkssite.bondwaresite.com/apology-laws-cms-143 (accessed 03/12/2018).
5. CMS ICD-10 Hospital Acquired Condition (HAC) Definitions Manual. Available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/hospital-acquired_conditions.html. (accessed 3/12/2018).
6. Garner BA. Black's Law Dictionary. 2014. 10th ed. Available at: Westlaw BLACKS.
7. American Medical Association (AMA) Survey: 4 in 5 Physicians Had a Cyberattack in Their Practices, Says Survey. December 12, 2017. Available at: https://www.ama-assn.org/4-5-physicians-had-cyberattack-their-practices-says-survey (accessed 03/12/2018).

PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP
11880 College Boulevard, Suite 300
Overland Park, KS 66210-2141

T 913.262.2585 • 800.562.5589
F 913.262.3633

NEWSLETTER EDITOR
Brian J. Thomas, JD
Vice President-Risk Management

ANESTHESIA & the LAW
A Risk Management Newsletter
MARCH 2018 – ISSUE 45

In This Issue