ANESTHESIA & the LAW
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Recent Cases Highlighted: PPM Returns to Courtroom Following Pandemic Pause

Missouri Unanimous Defense Verdict in Wrongful Death Trial

A 41-year-old woman presented for an elective total laparoscopic hysterectomy due to abnormal uterine bleeding attributed to fibroids. Two days before her procedure, the patient underwent routine pre-operative blood tests. The test results revealed a minimally low (2.7) potassium level. The anesthesiologist, a CRNA, and the surgeon reviewed the patient's medical record on the morning of surgery. The anesthesia team and surgeon recognized the lower potassium level but noted that the patient had been taking a diuretic for several years, which is known to lower potassium levels. The physicians discussed the patient's potassium level and decided to proceed with the procedure given the potassium level was only minimally low.

The procedure began without complications. Immediately after the surgeon placed the trochars and began insufflating the patient's abdomen, she became bradycardic. She did not respond to medication the anesthesia team administered. She then went into ventricular fibrillation, and CPR was initiated. Despite the use of additional medications, chest compressions, and multiple defibrillations for approximately forty minutes, the surgical team was unable to resuscitate the patient and she died. The suspected cause of death was cardiac arrest caused by a CO2 embolism.

The patient's two adult children sued the surgeon, the anesthesiologist, his anesthesia practice group, and the hospital. The surgeon settled for a confidential amount and the hospital was dismissed prior to trial.

Plaintiffs' theory of the case was that the anesthesia team did not perform the proper pre-anesthesia evaluation and testing, and that the procedure should have been delayed until the potassium level could be raised. Plaintiffs also claimed that the anesthesia team responded improperly to the patient's intraoperative cardiac arrest.

Plaintiffs' anesthesia expert, John H. Schweiger, MD from Tampa, Florida criticized the anesthesia team's failure to obtain a pre-procedure ECG and chest x-ray, and their failure to delay the procedure until the patient's low potassium could be addressed and resolved. Dr. Schweiger also opined that after the patient went into bradycardia, the anesthesia team acted below the standard of care in initially administering Robinol (which delayed the administration of Atropine), and ephedrine (which delayed the administration of epinephrine) and delaying the defibrillation for six minutes from the onset of ventricular fibrillation.

Defendants challenged Dr. Schweiger's criticisms and were able to use the patient's medical record to show the inaccuracies in his opinions. Dr. Schweiger admitted the medical literature he attempted to use to support his opinions did not contain the statements upon which he claimed to rely, thereby weakening his credibility and the weight of his opinions. Defendants also used Dr. Schweiger's extensive prior testimony (over 400 cases in 23 years) and income from testifying against anesthesia professionals (estimated to be over $9 million) to impugn his credibility and challenge his criticisms at trial. Dr. Schweiger could not overcome or explain away his prior testimony, including a prior deposition in which he gave a contrary opinion.

Defendants' anesthesia expert testified that everyone on the anesthesia team acted appropriately and within the

In This Issue

In March 2020, the COVID-19 pandemic essentially shut down courts and civil litigation across the country, including discovery and scheduled trials in multiple Preferred Physicians Medical cases. Currently, despite the ongoing pandemic and over two years of court shutdowns, false starts, and attempts to resume "normal" legal proceedings, Preferred Physicians Medical has continued its commitment to vigorously defend our ASA standard of care anesthesia professionals against claims and litigation. In this issue, we highlight some of our recent successes in the courtroom and offer some risk management analysis.

Thanks for reading,

Brian J. Thomas,
Editor

standard of care. He disagreed with plaintiffs' expert and testified there was no need to perform a pre-procedure ECG or chest x-ray. He also disagreed that the patient's surgery should have been postponed due to the potassium level, especially because safely correcting the potassium level was not a quick or simple process. The defense anesthesia expert also testified the anesthesia team's response to the patient's bradycardia was appropriate and met the standard of care, including the administration of Robinol and ephedrine. He also demonstrated, based on the anesthesia record, that the anesthesia team did not delay in defibrillating the patient, as Dr. Schweiger had suggested. The expert also agreed that the patient likely experienced a CO2 embolism, thereby causing her death.

Plaintiffs requested $1.3 million in damages from the jury during closing arguments. After a four-day trial, the jury deliberated approximately two hours and returned a unanimous defense verdict. The Court denied plaintiffs' motion for a new trial, and plaintiffs did not appeal. The Court awarded $4,908.91 in costs to the defense. PPM collected the entire cost judgment against the plaintiffs and their attorneys.

Greg Minana, Esq. and Tanya Maerz, Esq. of Husch Blackwell, LLP, St. Louis, Missouri represented PPM's insureds. Brian J. Thomas, Vice President – Risk Management, managed the file on behalf of PPM

Unanimous Defense Verdict in New York after COVID-19 Mistrial

A 36-year-old male presented to an ambulatory surgery center for pars plana vitrectomy. A PPM insured anesthesiologist provided MAC with sedation for the procedure. The patient had a history of diabetes, hypertension, hypercholesterolemia, chronic kidney disease, ischemic cardiomyopathy, coronary artery disease, peripheral artery disease, and lower extremity neuropathy. Ten months before the procedure, he suffered a myocardial infarction as the result of a LAD coronary artery occlusion, and two cardiac stents were placed.

The patient received supplemental oxygen and 150 mg of propofol, which was titrated slowly. Shortly after the ophthalmologist performed a peribulbar block and inserted a canula in the eye, the patient became bradycardic and hypotensive. The anesthesiologist promptly instructed the surgeon to stop the procedure, the drapes were removed, atropine and epinephrine were administered, and the patient was ventilated with a bag-mask. The patient became apneic, and a code blue was called. The anesthesiologist intubated the patient while another provider performed chest compressions. The patient developed PEA, and the code team administered 2 additional amps of epinephrine and atropine. Approximately eight minutes after the code was called, the patient's blood pressure, circulation, and spontaneous respiration were restored. The patient was transferred by EMS to an adjacent hospital.

Unfortunately, the patient was subsequently diagnosed with anoxic encephalopathy. After a 3-week admission, the patient was transferred from the hospital to a rehabilitation facility, where he resided for 15 weeks. The patient was then discharged home. He ultimately passed away approximately 4 years later. From the date of the procedure until his death, the patient never regained the ability to ambulate, speak, or perform daily functions.

The patient's mother brought professional negligence and wrongful death actions on behalf of the estate against the facility, the anesthesiologist, and the anesthesia practice group. The plaintiff alleged that the anesthesiologist caused the patient's injury by failing to properly monitor his ventilation during the procedure and neglecting to respond to the crisis in a timely manner.

Plaintiff's anesthesiology expert, Sheldon Deluty, MD, of Englewood, New Jersey, testified that the 100% oxygen saturation recorded by the anesthesiologist was inconsistent with a hypoxic brain injury and incompatible with the patient's outcome, and therefore, the anesthesia record was inaccurate. Dr. Deluty deduced the anesthesiologist did not properly monitor the patient's ventilation, and that the patient's heart became oxygen deprived, resulting in bradycardia and then PEA. Dr. Deluty further surmised the anesthesiologist did not administer rescue medications or intubate the patient until 3 minutes after the code was called. In forming his opinion, Dr. Deluty relied upon inconsistencies in the documentation, particularly regarding the handwritten times entered in the anesthesia record and the code sheet.

On cross-examination, Dr. Deluty was forced to acknowledge there are other causes of bradycardia besides oxygen deprivation, and that he had no objective evidence to support his assertion that the anesthesia record was inaccurate.

The defense anesthesiology expert testified the anesthesiologist recognized the patient's deteriorating vitals in a timely manner, and that appropriate measures were taken in response to the patient's falling blood pressure and diminished respirations. He strongly disagreed with Dr. Deluty's opinion that the anesthesia record was incompatible with the patient's outcome.

He explained that a patient who is properly ventilated can still experience a hypoxic brain injury if the heart is not circulating oxygenated blood to the brain. The patient's history of vascular disease and poor cardiac function further complicated the issue. The anesthesiology expert offered his opinion that the patient's apnea was preceded by bradycardia. This was likely triggered by the surgeon's block, which was a known risk of the procedure.

During closing arguments, plaintiff's attorney asked the jury to award $5,000,000 for pain and suffering and $1,000,000 to compensate the patient's son for loss of parental guidance. The jury deliberated for less than three hours before returning a 6-0 defense verdict in favor of the anesthesiologist, the anesthesia group, and the co-defendant facility. The case previously proceeded to trial in March 2020, but the judge ordered a mistrial after 2 weeks of testimony due to the COVID-19 pandemic.

Bruce Brady, Esq. of Koster, Brady, Nagler, LLP, New York, New York, represented PPM's insureds. Paul Lefebvre, Senior Claims Attorney, managed the file on behalf of PPM.

Florida Case Dismissed by Plaintiff During Trial

A 60-year-old female underwent a "Mini" facelift, bilateral blepharoplasty, and brow lift. PPM's insured anesthesiologist provided general endotracheal anesthesia for the procedure. Intubation was noted to be easy and atraumatic. After the procedure, and before the patient was extubated her head was wrapped. She was taken to PACU and later discharged home. At her two-week post-operative visit with the plastic surgeon, he noted it appeared her jaw was subluxed. He immediately obtained a consult with an oral surgeon. The patient was diagnosed with bilateral dislocation of the temporomandibular joint. She underwent jaw manipulation and conservative treatment for the inability to completely open and close her mouth.

The patient sued the plastic surgeon, his practice group, the anesthesiologist, and his practice group. She alleged the anesthesiologist was not negligent in causing her jaw dislocation but was negligent by failing to identify the dislocation and have it repaired before she was discharged. The patient claimed she was unable to close her mouth immediately following the surgery.

Prior to trial plaintiff sent a proposal of settlement to the anesthesiologist and plastic surgeon, but not their practice groups. The anesthesiologist and plastic surgeon wanted to defend their care, so the proposals were not accepted. The case proceeded to a two- week trial.

Plaintiff's anesthesia expert was John H. Schweiger, MD, from Tampa, Florida. He testified that the jaw dislocation occurred during intubation, most likely when the anesthesiologist was opening the patient's mouth. He also testified that the anesthesiologist was negligent for not diagnosing the dislocation prior to the patient's discharge. He testified further that the standard of care required the anesthesiologist to make sure the jaw was in the correct position when the patient was extubated. Even though there was no evidence in the medical record to support his opinion that the dislocation occurred during intubation, he testified the anesthesiologist or a CRNA should have called the patient the next day, which would have enabled them to diagnose the dislocated jaw.

James Bates, MD, an oral surgeon from Dallas, Texas, provided his trial testimony via video conferencing. It was his opinion the jaw dislocation occurred during intubation, but he could not rule out other possibilities. He testified that if it occurred during intubation, it would have been apparent to anyone looking at her. Dr. Bates testified that he chose to believe the history provided by the plaintiff over the medical record documentation and testimony of the anesthesiologist and plastic surgeon. It was his opinion that had the dislocation been diagnosed and corrected earlier, plaintiff would not have the problems with jaw pain and limited mouth opening she continues claim.

The defense anesthesiology expert testified a jaw dislocation can occur during intubation and is a known risk, but he did not believe it occurred at that time. If it had, it would have been obvious to the anesthesiologist and plastic surgeon. He said it is not standard of care for an anesthesiologist to routinely do a jaw examination of a patient post-extubation. Furthermore, the patient's face was heavily wrapped in bandages prior to extubation. Also, in an out-patient setting an anesthesiologist would not make a follow up phone call or contact the patient the next day unless the patient or surgery center contacted anesthesia services the next day with concern about an anesthesia complication.

Due to the strong testimony by defense experts, on the weekend following the first week of trial, plaintiff informed defense counsel she was dismissing her case. Gary Shipman, Esq. and William Whitney, Esq. of Dunlap & Shipman, PA, Santa Rosa Beach, Florida represented PPM's insureds. Shelley Strome, Senior Claims Specialist, managed the file on behalf of PPM.

Risk Management Analysis
Combatting Prolific Plaintiffs' Expert Testimony Against PPM's Insureds

The two anesthesiologists who served as plaintiffs' experts in the preceding case studies have testified in hundreds of depositions and dozens of jury trials against their fellow anesthesia professionals, including over 40 cases against PPM's insureds. These, and other prolific plaintiffs' experts, have made millions of dollars for their expert opinions and testimony. While these plaintiffs' experts often tout extensive and impressive curricula vitae, in PPM's experience, their opinions and testimony are often not supported by the medical evidence in the case and do not necessarily reflect accepted standards prevalent at the time of the event in question.

The American Society of Anesthesiologists (ASA) and the American Association of Nurse Anesthesiology (AANA) have issued guidelines[1] and a position statement,[2] respectively, "to limit uninformed and possibly misleading testimony." The ASA also allows for the submission of complaints by ASA members against other members for violation of these guidelines. Sanctions for violating these guidelines range from censure, suspension, or expulsion as a member of the ASA. Some state societies also have similar peer review programs that have sanctioned members for misleading and biased testimony that did not reflect generally accepted standards of care in the practice of anesthesiology. Additionally, while some state medical licensing boards consider expert testimony to be a subject to their review, few have disciplined physicians for unethical expert testimony.[3]

While PPM encourages and assists our insureds by providing deposition and trial testimony to submit to the ASA and state societies with any complaint alleging a violation of those guidelines for expert testimony, most plaintiffs' experts avoid these professional peer review programs by simply not belonging to those organizations. A more effective means for PPM to counter these plaintiffs' experts has been to work closely with our national panel of experienced defense trial attorneys in compiling a significant repository of these experts' deposition and trial transcripts. Given the immense amount of sworn testimony submitted by these experts, PPM and our defense counsel have been very successful in identifying former deposition and trial transcripts in which these experts have testified inconsistently with their testimony in current cases. "There is nothing quite as satisfying during a trial than using a plaintiff's expert's sworn testimony from a prior deposition or trial transcript to impeach their credibility with their own words in front of the jury," according to Paul Lefebvre, Senior Claims Attorney.

Unanimous Defense Verdict in Utah after "Never Event"

On December 30, 2015, a 47-year-old male underwent repair of a right hip fracture. A Hana fracture table was utilized for the procedure. General anesthesia via LMA was administered for the surgery. The patient was positioned on the Hana table with a perineal post and his feet locked into booms. At the end of the procedure the surgeon left the room, and the patient was slowly emerging from anesthesia. The anesthesiologist turned to throw the LMA in the trash can. At the same time, the physician's assistant who was at the patient's feet, unlocked the booms and removed the perineal post. The patient slid down the table, at which point the anesthesiologist attempted to slow the slide. The patient hit his head on the wheel cover of the Hana table sustaining a 2 cm laceration on the back of his head. Due to the attempt to assist with the slide, the anesthesiologist estimated the fall was approximately 6-8 inches. After fully emerging from anesthesia, the patient appeared lucid and did not complain of headache or neck pain. Five days post-procedure the patient complained of post-concussion symptoms including headache and neck pain. He was subsequently diagnosed with concussion symptoms. MRIs were negative for evidence of brain trauma. The patient also complained of neck pain and imaging showed degenerative disk disease at two levels of the cervical spine. The patient subsequently underwent cervical spine surgery for alleged ruptured disks. Following surgery, he continued to complain of neck pain, headaches, and short-term memory issues.

The patient and his wife filed a lawsuit naming the hospital, surgeon, surgical physician assistant, and PPM's insured anesthesiologist as defendants. The plaintiffs alleged all defendants were negligent in allowing the patient to fall from the Hana table. Specifically, plaintiffs alleged the hospital personnel failed to remain at the patient's side after removing the restraint that had been around the patient's chest, the surgeon failed to appropriately supervise and instruct the physician assistant on how to prepare the patient and table for transfer, the physician assistant removed the perineal post without ensuring everyone in the operating room was in the correct position for transfer, and the anesthesiologist turned away from the patient allowing him to fall.

Prior to trial, the hospital settled its case for a confidential amount. During the lawsuit, the anesthesiologist passed away. The case proceeded to trial with the surgeon, physician assistant, and the anesthesiologist's estate as defendants. The plaintiff, a local home builder, alleged the fall resulted in him sustaining permanent brain injury requiring the need for him to hire an additional employee to do the work he could no longer perform. He also alleged he suffered

from continuous headaches and neck pain requiring on-going medical treatment. Plaintiffs' anesthesiology expert, Dr. Jung Soo Yi, San Diego, California testified that the anesthesiologist is responsible for waking the patient up, making sure all personnel are in place for transfer, and then initiating the transfer. He testified that the anesthesiologist is the supervisor and should keep an eye on everything, and for the anesthesiologist to not have seen the physician assistant pull the perineal post was below the standard of care. He also testified that it was below the standard of care for the anesthesiologist to turn away from the patient to discard the LMA.

The anesthesiology expert in support of PPM's anesthesiologist testified that the standard of care was met. At the time of the fall, the anesthesiologist was focused on the patient at a critical time and was taking care of the airway. The anesthesiologist was not responsible for anything that helped restrain the patient to the Hana bed and was not responsible for the surgical team or their actions.

During trial, plaintiffs asked for $6,600,000 in compensation. After an eight-day trial, in less than 30 minutes, the jury returned a unanimous defense verdict for PPM's anesthesiologist and the remaining co-defendants.

David C. Epperson, Esq. and Scott H. Epperson, Esq. with the Epperson & Owens law firm in Salt Lake City, Utah defended the case on behalf of PPM's anesthesiologist and his estate. Shelley Strome, Senior Claims Specialist, managed the case on behalf of PPM.

Risk Management Analysis

"Never Events" Not Always Cases of Liability

Patient falls are typically defined as "never events," a term that was initially described in 2001 by the National Quality Forum (NFQ).[4] However, the definition and list of never events has been revised multiple times. Never events are currently defined as adverse events that are unambiguous, serious (resulting in death or significant disability), and usually preventable.

Our insureds' mere presence in the OR or patient care area when a never event occurs does not, in and of itself, result in liability against our insureds. In addition to proving the patient suffered actual damages (e.g., physical or emotional injuries), plaintiffs still have to prove that our insureds' acts or omissions were below the standard of care and caused the patient's injuries. As in the previous case study, PPM has successfully defended numerous cases in which plaintiffs' attorneys and their experts alleged our insureds were negligent if they were present during a never event (e.g., patient falls, OR fires, wrong-site procedures, etc.), despite compelling evidence of an alternative cause and that the patient did not have significant injuries.

Even though an adverse event like a never event might appear indefensible based on the initial available facts, PPM and our defense counsel have been successful in defending these cases with our thorough investigation of the facts and evidence, securing supportive testimony from highly qualified expert witnesses, and defending our insureds' care by educating juries that these types of adverse events can and do occur absent our insureds' negligence.

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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.

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