ANESTHESIA & the LAW
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PPM

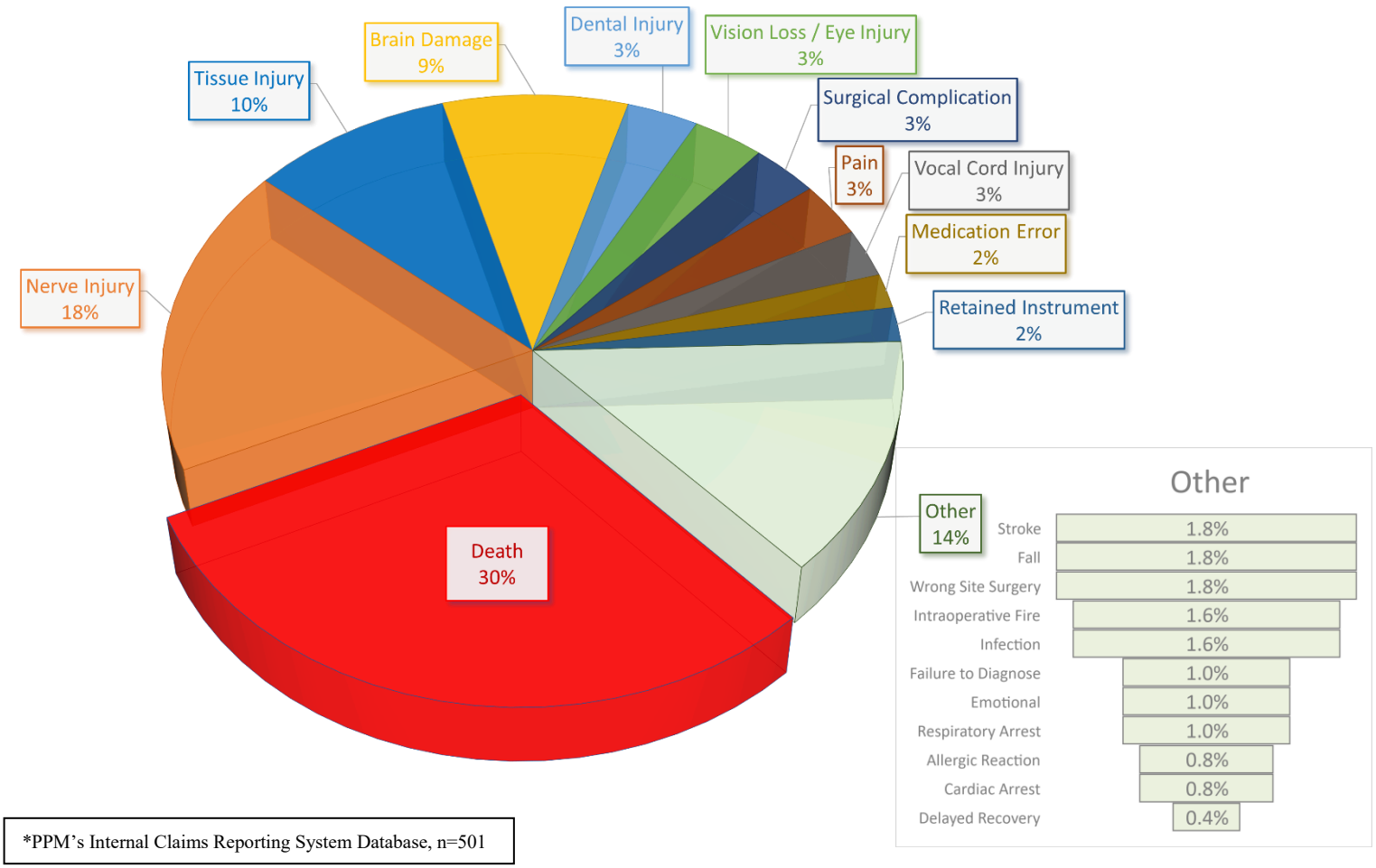
# Defending Wrongful Death Lawsuits in the Courtroom

## Introduction

Nearly every anesthesia professional will experience the death of a patient during their professional career. Patient deaths may result from unforeseen events or potentially unavoidable catastrophes during the care of critically ill patients. Some patient deaths might also be the result of errors or lapses of judgement by members of the surgical team. However, while the death of a patient is a traumatic and tragic event for the patient's family and loved ones, as well as the health care providers involved with the patient's care, many patient deaths are not the result of negligent care. In most cases, a thorough investigation following a patient's death reveals that Preferred Physicians Medical's (PPM) insureds met or exceeded the standard of care. In PPM's experience, our insureds are often named as defendants in wrongful death litigation based on numerous reasons and theories put forth by plaintiff attorneys, despite a lack of evidence of negligent care. In this issue, we highlight PPM's record of successfully defending our insureds in wrongful death litigation in the courtroom, examine some of the plaintiff attorneys' trial tactics and strategies, and offer some risk management analysis.

Over the past thirty-five years, there has been a significant reduction in anesthesia mortality to less than 1 in 200,000 healthy patients in developed countries, according to studies.[1] However, by the very nature of the practice of anesthesiology, anesthesia professionals may care for patients who experience serious complications resulting in death. Wrongful death litigation ranks #1 in the type of lawsuits defended by PPM on behalf of our insureds, as illustrated below. PPM has obtained defense verdicts in 46 out of the last 50 (92%) wrongful death trials on behalf our insureds, despite numerous significant challenges.[2] The following case studies highlight PPM's continued commitment to defend our insureds in wrongful death cases.

**Litigation Files By Injury Description – 2013-2022***




*PPM's Internal Claims Reporting System Database, n=501

## Case Study One

A 33-year-old male presented to an outpatient surgical hospital for lumbar microdiscectomy. A PPM insured anesthesiologist administered general anesthesia for the procedure. During the preanesthesia evaluation, the patient informed the anesthesiologist he had anxiety about undergoing surgery, and he reported his pain level was 7/10. The patient had tachycardia and hypertension prior to surgery, but his vitals were consistent with his reported pain. Induction was uneventful, and the patient was hemodynamically stable throughout the procedure. The neurosurgeon noted the patient lost 10 ml of blood intraoperatively. Following surgery, the patient was extubated in the OR and transferred to the PACU for recovery. The patient's blood pressure (BP) was below baseline upon emerging, and the PACU nurse administered a 250 ml fluid bolus pursuant to a standing order. As the patient became more alert, he reported significant pain in his lower back. The automated blood pressure cuff continued to reflect the patient was hypotensive. However, the PACU nurse noted the patient was thrashing around due to pain, and she was unable to keep his arm still while she attempted to measure his BP.

The PACU nurse contacted the anesthesiologist 25 minutes into the recovery period because she was concerned about the patient's persistent low blood pressure and was unsure about the reliability of the readings. The patient continued to report significant pain, and his inability to remain still complicated attempts to take his vital signs. The anesthesiologist testified that his differential diagnosis at this point included panic attack, limited pain tolerance exacerbated by anxiety, a medication reaction, vasoplegia, and internal bleeding. He explained bleeding did not initially rise to the top of his differential diagnosis because there was minimal blood loss during the procedure, the patient's abdomen did not appear distended, and the patient was not tachycardic or diaphoretic when he returned bedside. The anesthesiologist explained his initial focus was treating the patient's symptoms to help him identify the problem and pursue the best course of care.

After the anesthesiologist administered additional fluids, phenylephrine, and vasopressin without effect, he ordered 2 mg of midazolam. The patient was then able to fall asleep, approximately 1 hour after arriving in the PACU. With the patient now stationary, the PACU nurse cycled the BP cuff and noted his BP had returned to a normal range. However, the anesthesiologist remained concerned because the patient's HR was 115 after he fell asleep.

Fifteen minutes later, the neurosurgeon completed his second case of the day. The anesthesiologist apprised him of the initial patient's condition and suggested he cancel his next case so he could evaluate the first patient. The neurosurgeon asked the anesthesiologist to administer a midazolam antagonist to enable him to perform a neurological evaluation to assess whether the patient was experiencing pain secondary to a nerve injury. The PACU nurse asked the neurosurgeon if he would like to order a CT or labs, but no new orders were given. Shortly thereafter, the patient's respiratory rate increased, he became profoundly hypotensive, and there were signs of mottling. The anesthesiologist promptly called for the general surgeon and began placing lines in preparation for returning to the OR. The general surgeon responded to the PACU, and the decision was made to take the patient back to the OR for emergent exploratory laparotomy.

After making the incision, the general surgeon noted 2 liters of blood spilled out of the patient's abdomen. The patient had undergone an open procedure to repair a ruptured appendix several years earlier, and the subsequent adhesions complicated the general surgeon's efforts to reach the source of the bleed through the abdomen. He was eventually able to identify a large hematoma in the retroperitoneal space next to the aorta. A vascular surgeon arrived from a nearby medical center, but the surgeons were unable to place clamps or reach the aorta due to the adhesions. The vascular surgeon performed a thoracotomy and cross-clamped the aorta above the renal arteries in an effort to secure hemostasis from above the adhesions. The decision was made to transfer the patient to a medical center because the outpatient surgical hospital lacked adequate surgical resources, blood products, and an ICU. The anesthesiologist and vascular

surgeon rode with the patient in the ambulance and continued resuscitative measures in route to the medical center. Upon arrival, the vascular surgeon was able to locate and repair the source of the bleed, a 1 cm tear on the left side of the aorta. However, the patient developed acidosis and disseminated intravascular coagulation secondary to the hemorrhage. The patient remained in the OR for the next 5 hours while the anesthesiologist and other members of the surgical team attempted to stabilize the patient. The patient was then transferred to the ICU in critical condition, where he passed away later that night. The patient was survived by his wife and 1-year-old son.

The patient's family filed a lawsuit against the PPM insured anesthesiologist, the neurosurgeon, and the outpatient surgical hospital. The plaintiffs sent a $10,000,000 global settlement demand to the defendants at the conclusion of discovery. The parties mediated the case six weeks before trial, and the neurosurgeon and the facility reached confidential settlement agreements with the plaintiffs. The plaintiffs demanded policy limits to resolve their claims against our insured, threatening to pursue damages in excess of the available coverage if their demand was not accepted. Nevertheless, the anesthesiologist was resolute in defending his care and the case proceeded to trial.

During opening statements, it became apparent the plaintiffs' attorney would focus the vast majority of his case on damages and how the patient's death impacted his clients' lives, rather than on the medical care at issue. The plaintiffs' attorney also introduced a novel theory in this case, that the standard of care requires physicians to rule out the "worst-first" after forming a differential diagnosis. At the end of his opening remarks, the plaintiffs' attorney informed the jurors he would ask them to award his clients $18,000,000 at the conclusion of trial.

Plaintiffs' anesthesiology expert, John Brock-Utne, MD, of Palo Alto, California, testified that the anesthesiologist deviated from the standard of care by failing to timely recognize the patient was experiencing hemorrhagic shock, thereby delaying life-saving interventions. He contended any prudent anesthesiologist in the same situation would immediately order a CT, notify the surgeon of a potential bleed, measure the circumference of the patient's abdomen, draw blood for hemoglobin labs, and place a larger IV for rapid fluid infusion. Dr. Brock-Utne also advanced plaintiffs' attorney's theory that neglecting to rule out the "worst-first" after forming a differential diagnosis is a departure from the standard of care, testifying that since internal bleeding was the most serious complication on the anesthesiologist's differential diagnosis, he should have taken steps to rule it out before considering alternative causes of the patient's hypotension and pain. Lastly, he opined that the patient was past the point of no return by the time the anesthesiologist called for a general surgery consult, and but for the delay, the patient would have likely survived.

On cross-examination, Dr. Brock-Utne acknowledged he had never been in private practice or provided anesthesia services for a small hospital. He conceded a facility's staffing and resources should be considered in determining whether the standard of care has been met. He agreed it is exceedingly rare for a patient to sustain a major blood vessel injury during a microdiscectomy, and that he had personally encountered this complication only once during his 45-year career. In that instance, there was sudden drop in intraoperative BP, and the surgeon reported 600 ml of blood loss. Dr. Brock-Utne further testified the ultimate decision to take a patient back to surgery rests with the surgeon, not the anesthesiologist.

The defense anesthesiology expert testified the anesthesiologist adhered to the standard of care in every respect. He reiterated this was such a rare complication that the vast majority of anesthesiologists would not encounter a similar event during their careers, and he reminded the jury that the patient only lost 10 ml of blood and was hemodynamically stable during surgery. The defense anesthesiology expert stated that an anesthesiologist practicing under the same or similar circumstances would recognize and treat the most likely cause of a condition, and that prior to this trial, he had never heard the phrase "worst-first" to describe the standard of care for going through a differential diagnosis. He explained that the anesthesiologist appropriately identified the most severe potential causes of the patient's hypotension, and he never disregarded or ruled anything out. Instead, he attentively tried to narrow down his differential as he closely monitored the patient for notable changes, and once the patient exhibited additional signs of hemorrhagic shock, the anesthesiologist immediately called for the general surgeon and began preparing to take the patient back to the OR.

During closing arguments, plaintiffs' attorney suggested the anesthesiologist merely stood by and watched as the patient presented obvious signs of hemorrhagic shock. He also argued that diagnosing and treating conditions based on the "worst-first" principle is necessary because this type of event should never happen. The plaintiffs' attorney then proposed a person's life must be worth at least ten-times their earnings capacity, and he asked the jury to award his clients $18,000,000.

Defense counsel submitted to the jury that this was a case of misplaced blame, and that not every tragedy is someone's fault. He pointed out that the plaintiffs' attorney called two retained experts to provide subjective interpretations of the events at issue, but he did not ask a single clinician who was present that day to testify, not even our insured. Instead, the plaintiffs' attorney called eight witnesses to testify about damages. Defense counsel asked the jury to remember that our insured was the only witness to provide a chronological, detailed account of what happened, and that nobody involved in the patient's care dedicated more time and energy into the heroic efforts to save his life than the anesthesiologist. The jury deliberated for two hours before returning a 12-0 defense verdict in favor of our insured.

***He asked the jury to award his clients $18,000,000***

Jeff Brinkerhoff, Esq., of Brinkerhoff Law in Casper, Wyoming, represented the PPM insured anesthesiologist. Paul Lefebvre, JD, Lead Claims Professional & Risk Advisor, managed the file on behalf of PPM.

## Risk Management Analysis

PPM's recent success defending our insureds in wrongful death cases is a testament to more than 36 years of exclusively defending anesthesia professionals and their practices, our insureds' courage to defend their good care notwithstanding a case's potential damages, and our experienced defense attorneys skillfully counteracting plaintiff attorneys' trial tactics. For example, plaintiff attorneys frequently oversimplify or gloss over medical concepts, instead suggesting a tragic outcome could have been easily avoided if the defendant followed certain safety rules. They will imply the jurors can help protect themselves or their loved ones from similar events by returning a verdict for their clients. Plaintiff attorneys commonly focus their case on damages, rather than on the details surrounding the medical care at issue. By emphasizing their clients' relationships with the decedent and how the death affected them personally, plaintiff attorneys hope to engender sympathy and induce jurors to make decisions based on emotion rather than logical application of legal standards to the evidence presented at trial. In the case discussed above, the plaintiffs' attorney presented numerous videos and photos to the jury of the decedent spending time with family and friends. He also called more than a half dozen family members and friends to testify, while limiting testimony about medical care to the plaintiffs' retained experts and their subjective interpretation of the underlying events.

Moreover, experienced plaintiff attorneys will attempt to reduce the central premise of their case to a simple phrase or concept. These themes may be overgeneralizations of real principles, or they may be manufactured by plaintiff attorneys for the trial. This tactic can be challenging to overcome when plaintiff experts lend credibility to the theme, as the plaintiffs' expert did by endorsing the "worst-first" narrative. This ultimately backfired at trial when the defense expert testified that he had never heard that phrase before the week of trial, and he then went on to explain why the concept was inconsistent with the actual standard of care.

Plaintiff experts' willingness to improperly conflate best practices or personal custom with the standard of care is another obstacle the defense must overcome at trial. In the above case, the plaintiffs' expert suggested any prudent anesthesiologist would have taken a number of very specific, yet relatively simple, actions to diagnose and treat the patient's complication. With the benefit of hindsight and full knowledge of the patient's outcome, the plaintiffs' expert gave additional weight to details in the medical record that supported his opinions, while subtly minimizing or disregarding information that did not fit the overarching theme of the plaintiffs' case. As illustrated in the aforementioned case, experienced defense counsel can counteract this strategy by pointing out the plaintiffs' expert's unwillingness to give to equal weight to all of the information they reviewed, thereby impressing upon the jury that the expert is not being objective or impartial.

## Case Study Two

A 64-year-old female presented for peritoneal dialysis catheter placement. Her medical history was significant for congestive heart failure, hypertension, chronic obstructive pulmonary disease with continuous supplemental O2 dependence, an 80-pack year smoking history, granulomatosis with polyangiitis, and end-stage renal disease. The patient was assigned an ASA IV physical status classification based on her numerous significant co-morbidities. The patient also had a history of difficult intubation. The anesthesia care team decided to perform a rapid sequence intubation utilizing cricoid pressure and succinylcholine. The supervising anesthesiologist placed an endotracheal tube under direct visualization with a GlideScope at 1031. At 1040, the end-tidal carbon dioxide (ETCO2) level was 36, oxygen saturation (O2 SAT) 100%, and heart rate (HR) 106. Following intubation, the supervising anesthesiologist handed off the anesthesia care to the CRNA.

The procedure began at 1041 and the patient's abdomen was insufflated with carbon dioxide (CO2). At 1044, the CRNA noticed the patient cough, and she administered a paralytic before switching to hand ventilation. At 1048, the patient's HR, BP, and ETCO2 began to drop. The CRNA placed the patient back on the ventilator, and she administered phenylephrine and glycopyrrolate. The patient's HR and BP improved moderately by 1050, but the patient's low ETCO2 remained concerning. The CRNA administered additional doses of phenylephrine and glycopyrrolate, and the surgeon desufflated the patient's abdomen at 1053. The patient's condition continued to deteriorate, and the CRNA administered epinephrine while the circulating nurse called the supervising anesthesiologist. At 1056, the supervising anesthesiologist arrived in the operating room (OR) to assist. A code blue was called, and cardiopulmonary resuscitation (CPR) began at 1058. The patient was experiencing pulseless electrical activity (PEA). The supervising anesthesiologist performed a transesophageal echocardiogram (TEE) that showed the heart was empty and had no blood return. Despite the code team's efforts to resuscitate the patient, she expired approximately one hour later. The suspected cause of death was a venous gas embolism.

Following the patient's death, the surgeon wrote an operative note that was extremely critical of the CRNA's care and treatment. He wrote that the CRNA never informed him about the ETCO2 being low, she never asked him to desufflate or else he would have, and she disregarded his directive to administer atropine. He also documented that he instructed the circulating nurse to push the code button, but the CRNA overruled his decision. He wrote that after prompting the CRNA to call the supervising

anesthesiologist several times he had to order her to call the anesthesiologist directly.

The patient's husband and two adult children sued the PPM insured CRNA and the anesthesia practice group. The plaintiffs alleged, among other things, that the CRNA was negligent in failing to properly monitor the patient's condition during surgery, failing to properly and timely recognize, assess, and diagnose the patient's symptoms and conditions during surgery, and failing to adequately and timely communicate, notify, and inform other health care providers of the patient's condition during surgery leading to the patient's death. Plaintiffs' allegations against the anesthesia practice group were vicarious liability claims as the CRNA was their employee.

PPM secured anesthesiology and surgery experts who were fully supportive of our insured CRNA's care and treatment. At the conclusion of discovery and after being fully advised by defense counsel and PPM of the strengths and weaknesses of the defense, our insureds did not consent to settlement and indicated their desire to defend the anesthesia care at trial.

Plaintiffs' anesthesiology expert, Philip Bickler, M.D., Ph.D, from San Francisco, California, testified at trial that the CRNA was negligent for failing to administer a longer acting paralytic agent prior to the surgery start time so the surgeon could insufflate the abdomen more easily, failing to be vigilant and recognize the ETCO2 dropped and the patient was in a state of cardiopulmonary collapse, and failing to call the supervising anesthesiologist sooner to assist with the patient's cardiopulmonary collapse. Plaintiffs' expert also testified that gas embolisms are an "exceedingly rare, practically zero" complication of this procedure; therefore, he could completely rule out gas embolism as the cause of death. On cross-examination, defense counsel asked the plaintiffs' expert if he was aware that the surgeon in this case had two patients experience gas embolism complications during this exact procedure within the 18-month period preceding this procedure and one of those patients died. Defense counsel pointed out the surgeon's deposition testimony confirming these facts and asked the plaintiffs' expert that if gas embolism was such rare and unheard of complication, that it would be very unusual that the surgeon had two prior gas embolism complications while placing dialysis catheters. The plaintiffs' expert conceded he was not aware of the surgeon's two previous gas embolism complications or the prior patient's death.

Defense counsel called one of the nurses who was present in the OR when the events at issue occurred to the stand. She testified that she was training with the other circulating nurse and was there to observe. She testified that she didn't recall the patient's arms or legs moving (which contradicted the surgeon's deposition testimony), and that she would have remembered something unusual like that. She also recalled the CRNA communicating with the surgeon and that nobody "overruled" his request to call the code (as the surgeon testified to the day before). Additionally, other than the surgeon's operative note, none of the medical records or testimony from multiple health care providers who were present in the OR supported the surgeon's criticisms of the CRNA's care.

Following a nine-day trial, plaintiffs' counsel asked the jury to return a $9,000,000 award to the plaintiffs. The jury deliberated for less than 2.5 hours before returning a unanimous defense verdict in favor of the defendants.

Rick Harris, Esq. of Lamson, Dugan & Murray, LLP, Des Moines, Iowa represented PPM's insureds. Paul Lefebvre, JD, Lead Claims Professional and Risk Advisor, managed the file on behalf of PPM.

***Plaintiffs' counsel asked the jury to return a $9,000,000 award to the plaintiffs***

## Risk Management Analysis

The preceding case study is an example of how our insured CRNA and anesthesia practice group were named as defendants in a lawsuit based on, in large part, the surgeon's operative note that contained multiple egregious criticisms of our CRNA's care and treatment of the patient despite no other evidence to support those assertions. Following our investigation, PPM and our insureds' defense counsel evaluated this as a defensible case on the medicine for all involved health care providers. Our defense experts' opinions were that this was a very sick patient with multiple significant co-morbidities who was at increased risk undergoing any procedure and anesthetic who experienced a known, albeit rare, surgical complication — venous gas embolism — and did not have significant reserves to tolerate the complication.

Generally, a unified defense among all of the involved health care providers is the best approach to defending medical malpractice litigation. However, negative verbal comments about other health care providers' care to patients or their families or written criticisms in the chart against other health care providers following an adverse event and patient injury significantly increase the chance that a plaintiff attorney will accept and prosecute a case that might otherwise be evaluated as defensible on the medicine.

Additionally, blaming or finger-pointing among health care providers is a dream come true for plaintiff attorneys as most juries that see defendants fighting over liability will ultimately find in favor of the plaintiff. Finger-pointing between defendant health care providers can also significantly increase the overall value of a case if the jury

becomes angry due to the perception that none of the defendants are willing to take responsibility for a patient's injuries. How liability will be apportioned is determined by the jury; however, the likelihood of a verdict in favor of the plaintiff for a large award substantially increases.

**PPM offers the following risk management considerations and strategies for responding to unanticipated outcomes:**

- **CARE** for the patient first and foremost
- **DISCLOSE** the event to the patient, patient's family, or legal representative (if sufficient facts and information are known)
- **DOCUMENT** pertinent clinical information in the record, "known facts" about the event, description of care given in response, entry regarding disclosure discussion (when applicable), treatment and follow-up plans
- **DO NOT DOCUMENT** speculation or blame, subjective feelings or beliefs, references to incident report forms or communications with PPM
- **REPORT** to PPM as soon as practicable, notify appropriate organizations and agencies (if necessary)
- **ANALYZE & IMPROVE** systems and processes to advance patient safety

## Case Study Three

A 59-year-old male presented for an elective transurethral resection of the prostate (TURP) procedure. His medical history was significant for hypertension, prostatic hypertrophy, chest pain, heartburn, and asthma. Intermittent pneumatic compression (IPC) devices were placed on his lower extremities for venous embolism prophylaxis. General anesthesia with a laryngeal mask airway (LMA) was administered by a PPM insured anesthesiologist. The urologist utilized a pressure pump to infuse irrigation fluid into the bladder.

The first 90 minutes of the procedure were uneventful until the anesthesiologist noted that the patient was experiencing decreased oxygen saturation (O2 SAT) and increased airway pressure was required to ventilate. The anesthesiologist thought this was related to the LMA, so he intubated the patient. It was then noted that the patient's abdomen was distended, and the urologist was instructed to stop the procedure. An interventional radiologist was called to perform an abdominal ultrasound and paracentesis. The interventional radiologist removed 5 liters of fluid from the abdominal cavity due to a bladder perforation. The patient's status temporarily improved, but shortly thereafter the O2 SAT and BP both decreased and a code was called. An echocardiogram was performed which revealed a large clot in the heart. Tissue plasminogen activator (tPA) was administered; however, the thrombus resulted in obstructive cardiac shock and the patient expired.

The patient's wife filed suit against the anesthesiologist and his practice group. The urologist settled for a confidential amount with plaintiff prior to litigation being filed. Plaintiff alleged that the anesthesiologist failed to timely respond to warning signs that the patient was experiencing a surgical complication including changes in peak inspiratory pressure (PIP) and tidal volume. Plaintiff also alleged timely communication with the urologist would have alerted the surgeon to a complication before the accumulation of fluid in the abdomen resulted in a respiratory crisis.

During the anesthesiologist's deposition, the plaintiff's attorney asked him whether he had his cell phone with him in the OR during the case in question. Our insured answered yes, as he sometimes used it to communicate via text with other anesthesia personnel regarding the surgery schedule or requesting a break. As a result of our insured's deposition testimony, the plaintiff's attorney requested the court to issue a subpoena to allow the plaintiff to obtain the anesthesiologist's cell phone records from his cell phone carrier. The court granted plaintiff's motion for a subpoena and obtained the anesthesiologist's cell phone records. The cell phone records revealed that he had sent and received several texts approximately fifteen minutes before the complication with the patient's PIP and respirations was discovered.

A mediation was conducted following the completion of discovery. Plaintiff's settlement demand was $2,000,000. PPM's insured anesthesiologist did not consent to settlement and confirmed his resolve to defend his care and treatment at trial.

Prior to trial, the defense filed a motion to exclude the cell phone texting records from evidence at trial. The court reserved ruling on the issue and the case proceeded to trial. At trial, the court ruled in favor of the defense to exclude the cell phone texting records. The court reasoned that the probative value of the texts was substantially outweighed by the prejudicial effect to the anesthesiologist should the texts be introduced into evidence at trial. The court concluded that because the patient was stable and displayed no signs or symptoms of a surgical complication at the time the texts were sent and received, it would be highly prejudicial to the anesthesiologist to allow his texting into evidence.

Plaintiff's only expert was anesthesiologist, John H. Schweiger, MD, a prolific plaintiffs expert[3], from Tampa, Florida. Dr. Schweiger testified that the ventilator began to struggle because the patient's peritoneal cavity was filled with fluid, and that the failure to identify changes prior to that point was a violation of the standard of care. However, Dr. Schweiger failed to identify changes — other than a minor change in ventilatory settings due to a change in tidal volume — that would have prompted the anesthesiologist to develop a differential diagnosis and suspect a bladder perforation. Dr. Schweiger testified further that if the anesthesiologist had acted sooner the patient would not have died.

The defense anesthesiology expert testified that the anesthesiologist's actions taken when the ventilatory issues were noticed, including checking the ventilator, evaluating the airway, and considering pulmonary edema, complied with the standard of care. He also confirmed that there was nothing in the record to suggest that fluid began compressing on the diaphragm until the anesthesiologist first detected the ventilatory issues. Finally, he testified that the bladder perforation was a surgical complication that was not caused by the anesthesiologist.

Following a six-day trial, the jury returned a unanimous defense verdict. Plaintiff appealed the defense verdict. The plaintiff's primary argument on appeal was that the court should not have excluded the evidence of the anesthesiologist's texting during the case. The Appellate Court affirmed the lower court's decision that the texting should have been excluded and upheld the defense verdict.

Gary Shipman, Esq. and William Whitney, Esq. of Dunlap & Shipman, PA, Santa Rosa Beach, Florida represented PPM's insureds. Tracey Dujakovich, JD, Lead Claims Professional and Risk Advisor, managed the file on behalf of PPM.

## Risk Management Analysis

The above case study is another example in which PPM's insureds were named as defendants in a lawsuit in which the cause of the patient's injury and subsequent death was due to a surgical complication. Nevertheless, plaintiff attorneys are able to hire anesthesiology "experts" to offer testimony that is often inconsistent with the facts and evidence in the case. However, PPM and the defense attorneys and experts we retain to defend our insureds have been very successful in educating juries regarding the medicine and providing them with all of the evidence in the case (not just the facts and evidence cherry-picked by plaintiff attorneys and their expert witnesses) to weigh and consider in reaching their verdicts.

***While the defense verdict was ultimately upheld on appeal, the cost of securing that verdict was $590,614 and over six years of litigation***

The defense of the prior case was also complicated by allegations and evidence of our insured being distracted by the use of a personal electronic device (PED)[4] while administering care to a patient. As highlighted by this case study, courts have typically ruled that cell phone records and metadata are discoverable (i.e., the parties to the litigation are entitled to obtain that evidence). Fortunately, the defense attorneys for PPM's insureds were successful in excluding the texting evidence from being admitted at trial. However, the appeal by the plaintiff on the exclusion of that evidence underscores the plaintiff attorneys' strong belief that if that evidence had been submitted at trial, the jury would have awarded his client a significant plaintiff's verdict. And while the defense verdict was ultimately upheld on appeal, the cost of securing that verdict was $590,614 and over six years of litigation.

**PPM offers the following risk management considerations and strategies to eliminate or reduce distractions from non-clinical PED use in patient care areas:**

- Review and comply with practice facilities' PED policy statements, guidelines, and policies
- Implement a "sterile cockpit"[5] protocol during critical phases of procedures
- Limit personal telephone calls and text messages to urgent or emergent situations
- Keep telephone calls to a minimum and brief as possible
- Avoid discretionary internet-based activities

PPM's in-house claims attorneys and professionals are available 24/7 to assist our insureds with any matter affecting their anesthesia practice.

## References


1. Greenberg S. The Anesthesia Patient Safety Foundation (APSF): A 35 Year Commitment to Patient Safety. APSF Articles Between Issues. June 10, 2021. Available at: https://www.apsf.org/article/the-anesthesia-patient-safety-foundation-apsf-a-35-year-commitment-to-patient-safety/

2. Preferred Physicians Medical Risk Retention Group, a Mutual Company claims reporting system database.

3. *See*, Anesthesia & the Law, "Recent Cases Highlighted: PPM Returns to Courtroom Following Pandemic Pause." Issue 53, October 2022. Available at: https://files.norcal-group.com/hubfs/PPM/Issue53.pdf?__hstc=50663606.29dd91e1b40a137e71af91b9be1e15c8.1643751000750.1696517052517.1696524903484.168&__hssc=50663606.5.1696524903484&__hsfp=136684467

4. PED includes any device used for personal use or communication including, but not limited to, smart phones, iPads, iPods, laptops, and personal computers.

5. The sterile cockpit concept is derived from aviation law that prohibits crewmembers from engaging in any activity except those duties required for the safe operation of the aircraft during critical phases of flight, including taxi, takeoff, landing, and all other flight operations conducted below 10,000 feet. "Sterile" periods in health care include but are not limited to: induction and emergence of anesthesia, critical events during the anesthetic or surgery, and unanticipated events requiring additional OR team communication.

**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

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## In This Issue

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- Defending Wrongful Death Lawsuits in the Courtroom
- Risk Management Considerations, Strategies, and Resources for Defending Wrongful Death Lawsuits