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PPM

The Geography of Anesthesia Liability: How Practice Location Impacts Malpractice Exposure

Introduction

Across the country, medical liability exposure varies dramatically by jurisdiction, shaped not only by statutes and procedural rules, but also by local legal culture. Factors such as whether a venue is historically plaintiff or defense oriented, the absence or implementation of tort reform measures, the experience and impartiality of the judiciary, the sophistication and aggressiveness of the plaintiff's bar, and the prevalence of "nuclear" verdicts significantly impact both the likelihood of being named in a medical malpractice lawsuit and the outcome of litigation. Layered on top of these structural differences are broader forces such as social inflation, expanding theories of liability, and jury skepticism toward institutional defendants and the corporatization of healthcare, which tend to amplify liability exposure in certain parts of the country. Understanding how geography intersects with professional liability risk is critical for anesthesia professionals considering new practice opportunities or reassessing their current risk profile in a rapidly changing legal landscape.

In this issue, we explore two case studies to highlight how improper judicial rulings regarding the admissibility of expert testimony and other evidence can unduly prejudice defendants and alter the outcome of trials.

Case Study #1

In 2002, a 71-year-old female underwent a quadruple coronary artery bypass procedure. Postoperatively, the patient developed recurrent hypotension and required emergency re-exploration in the intensive care unit. It was determined that she sustained a rupture of her right pulmonary artery caused by a Swan Ganz catheter. The patient subsequently experienced cardiac arrest and died approximately ten hours after the procedure.

In 2003, the patient's husband filed suit against a PPM insured anesthesiologist, his anesthesia practice group, the cardiothoracic surgeon, several nurses, and the hospital. All individual co-defendants, with the exception of the anesthesiologist, were hospital employees.

The plaintiff initially alleged that the anesthesiologist negligently failed to obtain informed consent for pulmonary artery catheterization and negligently failed to properly perform and monitor the Swan Ganz catheter. However, the plaintiff was unable to retain a medical expert to support the negligence allegation, as pulmonary artery perforation is a well-recognized complication of Swan Ganz catheterization. As a result, the plaintiff amended the complaint, dismissed the negligence claim, and instead alleged medical battery, asserting that the anesthesiologist failed to obtain proper consent for Swan Ganz catheterization.

"THIS CASE, WHICH DRAGGED ON FOR SIXTEEN YEARS, UNDERSCORES EXACTLY WHY ST. CLAIR COUNTY, ILLINOIS HAS CONSISTENTLY BEEN RANKED AMONG THE NATION'S TOP JUDICIAL HELLHOLES™"

During discovery, it was established that no separate, procedure specific consent had been obtained for Swan Ganz catheterization. The patient had signed a general consent authorizing

the physicians to perform "insertion of central venous pressure and/or arterial line." The defense anesthesiology expert explained that the standard of care does not require separate consent for procedures that are an integral part of cardiac surgery. The expert opined that a general consent for heart surgery includes consent for all procedures reasonably necessary to perform the surgery, including general anesthesia, Swan Ganz catheterization, and arterial line placement. Critically, the plaintiff was unable to obtain an expert willing to opine that Swan Ganz catheterization required a separate consent form.

Over the next ten years, the trial court granted the plaintiff numerous discovery extensions and trial continuances and issued a series of unfavorable rulings against the defendants. Throughout this period, and despite several attempts by the plaintiff to resolve the case through settlement, the anesthesiologist maintained that he had not been negligent and refused to consent to settlement.

In 2014, three weeks before trial, the court granted the plaintiff's motion for summary judgment, ruling that as a matter of law, placement of a central venous pressure line was substantially different from placement of a Swan Ganz catheter. The court ruling essentially stated that a medical battery had occurred, leaving only causation and damages to be decided by the jury at trial.

One week before trial, defense counsel was notified that the hospital had settled on behalf of the cardiothoracic surgeon, nurses, and the hospital for a confidential amount.

On the eve of trial, the court ruled that the anesthesiologist would not be permitted to offer any opinions during trial testimony, including opinions he previously expressed in response to plaintiff attorney's questioning at his deposition. During the three-day trial, the defense was effectively prohibited from presenting expert testimony, the anesthesiologist's testimony, or any other evidence in support of the anesthesiologist's care. The defense was also barred from cross examining the plaintiff's witnesses.

After the defense rested, the plaintiff moved for a directed verdict on causation. Defense counsel opposed the motion and provided Illinois case law establishing that causation is a question of fact for the jury. Despite well settled Illinois precedent holding that granting a directed verdict under these circumstances constitutes reversible error, the court granted the plaintiff's motion.

During closing argument, the plaintiff requested damages of at least $1,000,000 but "no more than" $2,000,000. After deliberating for less than three hours, the jury returned a verdict awarding the plaintiff $1,000,000.

The court denied all post-trial motions and ordered the defendants to post a $1,200,000 appeal bond. PPM posted the bond, and defense counsel pursued an appeal.

In March 2015, the Illinois Court of Appeals reversed the trial court's rulings and remanded the case for a new trial. The appellate court

agreed with the defense on each issue raised and repeatedly instructed the trial court to follow established law on remand.

A second trial was scheduled before the same judge for September 2019. Shortly before trial, defense counsel notified PPM's insured anesthesiologist that the plaintiff had voluntarily dismissed the case.

"This case, which dragged on for sixteen years, underscores exactly why St. Clair County, Illinois has consistently been ranked among the nation's top Judicial Hellholes™. I have never seen such an egregious disregard for legal and ethical obligations in my entire career," said Shelley Strome, Senior Claims Specialist. "I am incredibly happy for our insured and thankful that he never wavered in defending his care, despite all odds stacked against him in this jurisdiction." PPM incurred a total of $524,987 in defense costs in this case.

Case Study #2

A 32-year-old patient at 25 weeks' gestation was transported to a level III Trauma Center by EMS due to antepartum hemorrhage. The patient's pregnancy was complicated by placenta previa and placenta accreta, and her obstetric history included four prior deliveries by cesarean section (C-section). The patient's obstetrician-gynecologist (OB) met the patient outside the emergency department, and the patient was transferred directly to the operating room. A PPM-insured anesthesiologist responded to the OR moments before the patient and the OB arrived. There, the OB performed a vaginal examination and noted minor bleeding that became more significant with insertion of a speculum. The OB called for an emergency C-section, and she informed the patient and her husband that she might need to perform a hysterectomy as a life-saving measure.

The anesthesiologist obtained informed consent from the patient and her husband before administering general anesthesia with rapid sequence induction. Upon entering the peritoneum, the OB found portions of the placenta floating in the abdomen, and she noted there was amniotic fluid tinged with blood. The OB discovered a uterine rupture on the anterior wall of the uterus with one of the infant's extremities visible in the peritoneum. The infant and remainder of the placenta were delivered approximately one minute later. The OB noted there was no active bleeding and the uterus contracted following delivery. Accordingly, she elected to suture the uterus in lieu of performing a hysterectomy.

After closing the abdomen, the OB noticed the patient's skin appeared diaphoretic. The patient became increasingly hemodynamically unstable over the course of the next ten minutes, and a code was called. The anesthesiologist placed an arterial line and two partners from his group responded to the OR to assist. The patient was resuscitated a short time later. However, ten minutes after she was stabilized, the patient was noted to be bleeding vaginally and from incision site. The OB elected not to reopen the abdomen to perform a hysterectomy as she was concerned the patient was developing disseminated intravascular coagulation (DIC). Amniotic fluid embolism (AFE) was also included in her differential diagnoses. Over the ensuing hours, the anesthesiologists administered large quantities of blood products, including red blood cells, plasma, platelets, cryoprecipitate, as well as bicarbonate and calcium to address evolving metabolic acidosis and coagulopathy. Monitoring and laboratory results demonstrated a progression from initially normal coagulation parameters to severe DIC, consistent with either uncontrolled hemorrhage or a possible AFE.

Efforts to stabilize the patient with pressor support and massive transfusion protocol were unsuccessful, and the decision was made to

transfer the patient via air ambulance to a level one trauma center. Upon arrival, she underwent exploratory laparotomy and resuscitative thoracotomy while on vasopressor support. Surgeons noted ongoing uterine pathology and bleeding, but despite further surgical and resuscitative efforts, the patient went into cardiac arrest and passed away later that morning. The Medical Examiner attributed the cause of death to uterine rupture, hemorrhage, and coagulopathy due to placenta previa/accreta.

"IN AN UNUSUAL TURN OF EVENTS, THE FACILITY THEN FILED A THIRD-PARTY CLAIM AGAINST THE PPM-INSURED ANESTHESIOLOGIST, CONTENDING THE HOSPITAL IS ENTITLED TO COMMON-LAW CONTRIBUTION FROM THE ANESTHESIOLOGIST FOR ANY CLAIMS RELATED TO INTRAOPERATIVE MONITORING OR ADMINISTRATION OF BLOOD PRODUCTS."

The patient's husband filed a lawsuit in New York County, New York against the OB and the facility on behalf of himself and his five children for loss of companionship and parental guidance, respectively. Plaintiff alleged that the OB was negligent in failing to perform a hysterectomy following delivery of the infant, and he asserted claims against the hospital for vicarious liability and failing to maintain appropriate protocols relating to the management of high-risk obstetrical emergencies. In an unusual turn of events, the facility then filed a third-party claim against the PPM-insured anesthesiologist, contending the hospital is entitled to common-law contribution from the anesthesiologist for any claims related to intraoperative monitoring or administration of blood products.

Over seven years later, the case ultimately proceeded to trial. In addition to supportive standard-of-care experts, the defendants intended to call experts to support their causation defense that an AFE played a role in the patient's sudden cardiovascular collapse, DIC, and death. Midway through trial, the plaintiff attorney objected to the defendants presenting their AFE alternative causation theory on the basis that the medical records did not indicate the patient was hypoxic prior to the initial cardiac arrest. The trial judge conducted a hearing outside the presence of the jury to determine whether the defense expert's opinions were based on generally accepted scientific principles shared within the medical community. In a shocking decision, the trial judge ruled in favor of the plaintiff. The trial judge ordered that all AFE-related causation testimony be stricken from the record, and the jury was instructed to disregard evidence that AFE played any role in the decedent's sudden cardiovascular collapse, DIC, and death. At the conclusion of trial, the jury awarded plaintiffs $5,000,000.

The defendants appealed the judgment. The defendants' primary issue on appeal was that the trial judge erred in categorically excluding expert testimony regarding the defense's AFE causation theory. Defense counsel argued the trial judge's decision was a medically and legally erroneous application of the standard for allowing expert testimony. The defense contended the trial judge improperly disregarded uncontroverted evidence that the patient exhibited the other classic AFE symptoms, and she gave no consideration to expert opinions and medical literature recognizing AFEs can occur without hypoxia. Defense counsel maintained that at a minimum, differing opinions about AFE presentation should have been issues of weight and credibility for the jury to decide. By unilaterally eliminating the defense's sole causation theory midway through trial, the trial judge's ruling constituted procedural prejudice that deprived the anesthesiologist and the other defendants of a fair trial.

The Appellate Justices found the defendants' arguments compelling and persuasive, and the Court of Appeals entered a unanimous decision in their favor. The Court of Appeals ordered the $5,000,000 judgment vacated and remanded the case back to the lower court for a new trial. Appreciating it would be much more challenging to

prevail at trial with the defendants presenting their causation defense, the plaintiff attorney approached the defendants regarding settlement. The anesthesiologist was understandably weary of a second trial after more than a decade of litigation. Accordingly, with the consent of our insured, PPM reached a compromise resolution with plaintiffs for an amount reflecting the defensibility of the case. PPM incurred a total of $488,246 in defense costs in this case.

Discussion

Judicial bias and inexperience can create a hostile venue for defendants and have a considerable impact on trial outcomes, particularly in complex litigation such as medical malpractice. An inexperienced judge may lack familiarity with technical evidentiary standards, expert testimony frameworks, or the limits of gatekeeping doctrines, increasing the risk that discretionary rulings drift from neutral case management into substantive interference. When inexperience is coupled with implicit bias, such as a belief that healthcare institutions and clinicians should bear the "outcome risk" regardless of fault, the courtroom can subtly but materially tilt against the defense.

This dynamic most often manifests through uneven evidentiary rulings, premature credibility assessments, or misapplication of judicial doctrine. These factors can result in the exclusion of legitimate defense theories while plaintiffs' narratives are permitted to reach the jury unchecked. Judges unfamiliar with the boundary between admissibility and weight may inadvertently substitute their own judgment for that of jurors, particularly in cases involving scientific uncertainty or competing expert opinions. Over time, repeated interventions of this nature can erode the appearance of neutrality, undermine defense credibility, and distort the adversarial balance.

A hostile venue is further reinforced when a judge's courtroom commentary or feedback in the presence of jurors appears to validate a plaintiff's legal theory or "correct" perceived imperfections in a plaintiff's presentation of evidence, while holding defendants to a stricter procedural or evidentiary standard. The cumulative effect of such rulings can deprive defendants of a fair opportunity to present their case and shift outcomes away from merits-based adjudication. From a claims and underwriting perspective, recognizing these dynamics is critical, as adverse verdicts in such environments may be a reflection of institutional failure rather than substantive liability, making these types of cases especially vulnerable to appeal but more costly and unpredictable at the trial level. More importantly, in PPM's experience, defending good care in these jurisdictions is typically more time-consuming and stressful for our insureds.

The following table highlights key differences across select states, emphasizing how venue can influence litigation frequency, claim severity, time to resolution, statutes of limitations, damage caps, and other factors that shape anesthesia-related liability exposure.

State	Litigation Frequency	Litigation Severity	Length of Litigation	Plaintiff or Defense Oriented	Statute of Limitations (SOL)	Damage Caps	Key Features and Trends
AZ	Moderate	Moderate–High	Long	Balanced	2 years	None	Severity is trending higher, particularly in urban areas; state constitution impedes legislative tort reform initiatives
MD	Moderate	Moderate–High	Long	Plaintiff Leaning	5 years	Non-economic only w/ annual increase for inflation: $920,000 for injury and single beneficiary wrongful death; $1,131,250 for multi-beneficiary wrongful death (2026)	Steady cap increases and social inflation have led to increased severity in recent years; venue significantly impacts exposure as urban areas remain plaintiff oriented
MO	Moderate	Moderate	Moderate	Balanced	2 years for injury cases 3 years for wrongful death	Non-economic only w/ annual increase for inflation: $481,493 for non-catastrophic injury; $842,614 for catastrophic injury (2026)	Stable environment with incremental cap growth; remains defense oriented outside core urban areas; plaintiffs frame cases around life-care-planning to inflate economic damages
NY	Very High	Very High	Very Long	Strongly Plaintiff Oriented	2.5 years for injury cases 2 years for wrongful death	None	Aggressive plaintiff's bar; lack of expert discovery increases overall litigation frequency and number of meritless claims; social inflation entrenched and verdict awards escalating
TX	Low-Moderate	Low–Moderate	Short–Moderate	Defense Oriented	2 years	Non-economic only: $250,000 for each individual clinician; $500,000 for institutions	Very stable jurisdiction post tort reform; procedural dismissals more common than in other states; urban areas trending more plaintiff leaning
UT	Moderate	Low–Moderate (injury) / Moderate–High (death)	Moderate	Defense Leaning	2 years	Non-economic for injury cases only: $450,000 No cap for wrongful-death cases	Increase in litigation frequency and filing of meritless claims following screening panel reform, particularly in death cases; malpractice environment is otherwise stable
VA	Low–Moderate	Moderate	Short–Moderate	Balanced	2 years	Total cap on all damages w/ annual increase for inflation: $2,750,000 (2026)	Severity is predictable w/ cap but trending higher due to annual increases and social inflation; plaintiff's bar actively attempting to repeal or substantially increase cap

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Glossary of Key Legal & Litigation Terms

Economic Damages | Financial losses that can be objectively calculated and documented, such as medical expenses, lost wages, and future care costs.

Example: Future life care costs following a hypoxic brain injury in a delayed airway management case.

Non-Economic Damages | Compensation for intangible losses without a fixed monetary value, including pain and suffering or emotional distress.

Example: A patient experiencing intraoperative awareness seeks damages for psychological trauma.

Litigation Frequency | The rate at which claims or lawsuits are filed within a given population or time period.

Example: An increase in claims following regional block complications reflects rising litigation frequency.

Litigation Severity | The financial magnitude of claims, typically measured by indemnity payments and defense costs.

Example: A catastrophic birth injury involving anesthesia management results in a high-severity claim.

Directed Verdict | A ruling by a judge removing a case or issue from jury consideration due to insufficient evidence.

Example: A claim is dismissed mid-trial after no evidence supports a breach of the anesthesia standard of care.

Nuclear Verdict | An exceptionally large jury award that exceeds $10 million.

Example: A jury issues a $20 million verdict following an anesthesia-related airway event.

Judicial Hellholes™ | A term coined by the American Tort Reform Association to describe jurisdictions perceived as particularly favorable to plaintiffs, often associated with higher verdicts and expanded liability theories.

Example: An anesthesia claim venued in a historically plaintiff-friendly county results in significantly higher settlement exposure.

Social Inflation | A trend of rising claim costs driven by societal factors such as jury attitudes, anti-corporate sentiment, and expanding liability theories.

Example: Juries increasingly view large businesses such as healthcare as faceless entities that prioritize profits over patient safety, leading to often irrational plaintiff verdicts that far surpass historical norms.

Underwriter's Spotlight - Has Something Changed? Please Let Us Know

At PPM, we understand that professional or personal circumstances may lead our insureds to change practice locations from time to time. Whether a change is planned or unexpected, even routine updates can have important implications for coverage.

For that reason, **PPM Policy 5-5 (Practice Changes)** asks policyholders to notify PPM of **any material change in their practice**. Keeping us informed helps ensure your coverage continues to reflect your current practice and allows us to address potential underwriting and risk management issues before they invite liability exposure.

Please contact our policyholder services team to report notable changes, such as:

- Updates to your name, address (home or practice), phone number, or email
- Adding or leaving practice locations, or relocating to another state
- Changes in how or where you practice, including office-based work, mobile services, pain management, locum tenens, or similar arrangements
- Time away from practice due to health-related issues, sabbaticals, or volunteer medical work
- New hires or departures within an anesthesia practice group

Timely communication allows PPM to review changes and determine whether any underwriting review or policy updates are needed, which will help avoid unintended gaps in coverage. Please note that failure to notify PPM of material practice changes may affect coverage in the event of a claim.

PPM's policyholder service representatives, underwriters, claims attorneys, and business development representatives are available to assist with practice changes and related questions. Our-in house legal and claims professionals can help review contracts, anesthesia services agreements, informed consent documents, and practice policies to help manage liability exposure.

If your practice has changed, or if you are considering a change to your practice location, we encourage you to reach out. A brief conversation now can help ensure continued protection later.

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