PPM ANESTHESIA & the LAW
A RISK MANAGEMENT NEWSLETTER

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ISSUE 29

Wrongful Death: Arizona Defense Verdict

A Maricopa County, Arizona jury returned a unanimous defense verdict in favor of a PPM insured anesthesiologist and his anesthesia practice group in a wrongful death lawsuit.

The lawsuit involved a 46 year-old male patient, ASA IV due to morbid obesity and related medical conditions, status post CABG, who underwent laparoscopic gastric bypass surgery on May 16, 2006. Signs and symptoms of a blockage emerged shortly after the initial surgery. The surgeon returned the patient for an exploratory laparotomy on May 17, 2006. The PPM insured anesthesiologist was the anesthesiologist for both procedures. During the second procedure, both the PPM insured anesthesiologist and the surgeon noted a release of succus into the abdomen when the surgeon removed the obstruction. The surgeon diluted and suctioned out the spillage of succus and returned the patient to the PACU in what was, initially at least, stable and satisfactory condition. During the PACU stay, however, the patient demonstrated an increased heart rate trending upward. The surgeon had ordered he be contacted by nursing if the patient's heart rate reached 120 bpm. The patient also demonstrated 10/10 pain that was not responding to morphine. Instead of calling the surgeon, the nurses first contacted the PPM insured anesthesiologist.

Having been involved in the patient's prior surgery, the PPM insured anesthesiologist was aware of the patient's pre-existing pain conditions, which also rated on a 9/10 to 10/10 scale even before the take-back procedure. Therefore, the PPM insured anesthesiologist initially questioned whether the patient's tachycardia might be attributed to his uncontrolled pain. The PPM insured anesthesiologist switched from morphine to Dilaudid for pain control and also ordered a fluid bolus. Importantly, the PPM insured anesthesiologist did not order blood gases or a CBC during the patient's PACU stay. It was the failure to order these blood tests that ultimately became the plaintiffs' primary focus of criticism of the PPM insured anesthesiologist's care.

The PPM insured anesthesiologist returned to examine the patient in the PACU during the approximate 90-minute timeframe during which he had ordered the switch to Dilaudid and the fluid bolus. Toward the end of that 90-minute timeframe, the PPM insured anesthesiologist had ruled out an anesthesia-related problem and determined the patient's problems were most likely surgical in nature, and most probably the result of chemical peritonitis stemming from the spillage of succus during the earlier surgery. Nonetheless, the

In this Issue

We once again highlight some of our recent successes in the courtroom. As illustrated by several of the cases reported in this issue, the PPM policyholder's resolve and commitment to defend his or her care is a significant factor in successfully defending medical negligence lawsuits. Plaintiffs faced with a PPM policyholder committed to defending his or her care through trial and the possibility of owing PPM a significant cost judgment in the event of a defense verdict have dismissed cases even after years of litigation. PPM continues to aggressively pursue cost judgments awarded against plaintiffs following defense verdicts. To date, PPM has secured over $1.26 million in judgments against plaintiffs who have sued PPM policyholders.

We also address a frequently asked question by PPM policyholders, "What events should be reported to PPM?" Prompt notification of any adverse medical outcome not only initiates coverage under your PPM insurance policy, it also enables PPM's claims attorneys and claims specialists to provide you with real-time, specific risk management advice that may help minimize the possibility of a claim or lawsuit. As noted in the insert, PPM encourages its policyholders to seek our assistance regardless of the severity of the injury and upon the occurrence of certain other events. PPM's claims attorneys and claims specialists are available 24 hours a day, 7 days a week via our automated after-hours answering service by calling 1-800-562-5589.

Thanks for reading,

Brian J. Thomas, Editor

PPM insured anesthesiologist thought it prudent to involve the surgeon at this juncture. The PPM insured anesthesiologist requested the PACU nurse call the surgeon to update him on the patient's condition and seek disposition orders.

The PACU nurse placed a call to the surgeon, which she characterized as a 30-45 second phone call during which the surgeon was extremely "short" with her. The PACU nurse claimed to have informed the surgeon of the patient's tachycardia, but the surgeon attributed that finding to the fact that the PACU nurse had allowed the patient up out of bed to use the bathroom for approximately an hour. Both the nurse and the surgeon testified at deposition the surgeon instructed the nurse to return the patient to bed and then discharge him to a general nursing floor.

The PPM insured anesthesiologist returned to the PACU just after midnight to find it dark and empty. He concluded the patient must have met discharge criteria, or the surgeon had transferred him to either telemetry or the ICU. The PPM insured anesthesiologist was not contacted about the patient thereafter, and all parties agreed he was no longer involved in the patient's care after he was discharged from the PACU.

Throughout the early morning hours of May 19, 2006, the patient's tachycardia continued. Multiple nurses testified about having made several telephone calls to the surgeon, all of which the surgeon denied ever receiving. The surgeon's phone records indicated no phone calls were placed to him. The surgeon returned to the hospital and personally examined the patient in the early morning hours of May 19, 2006. The surgeon did not return the patient for exploratory surgery even after noting sustained tachycardia throughout the entire prior evening. Later in the afternoon on May 19, 2006, the patient progressed into septic shock, ultimately demonstrating signs of a necrotizing fasciitis infection that resulted in his death the next day.

The patient's surviving spouse and her three minor children filed suit against the PPM insured anesthesiologist, his anesthesia practice group, the surgeon and the hospital. The surgeon and hospital settled out of the lawsuit for an undisclosed sum early in the litigation. The marked discrepancy between the sworn testimony of the surgeon and the nurses likely explains why both parties settled out very early in the litigation.

The PPM insured anesthesiologist and PPM attended a court-ordered mediation prior to trial. Following consultation with defense counsel and PPM, the PPM insured anesthesiologist felt strongly his care was appropriate and met the standard of care. PPM and defense counsel had also secured supportive expert opinions on the PPM insured anesthesiologist's behalf. Therefore, the PPM insured anesthesiologist did not consent to settlement and PPM offered no money to plaintiffs. In response, plaintiffs' attorney told the mediator he would be asking the jury to return a $10 million verdict at trial. As a result, the PPM insured anesthesiologist, PPM and defense counsel prepared for trial. The PPM insured anesthesiologist and his anesthesia practice group were the only defendants at trial.

Plaintiffs retained anesthesiologist Mark Singleton, M.D. from San Jose, California, who testified the PPM insured anesthesiologist fell below the standard of care by not ordering blood gases, a CBC, and by not "personally" informing the surgeon of the PPM insured anesthesiologist's diagnosis of chemical peritonitis. Dr. Singleton believed that had the blood gases and CBC been ordered they would have been abnormal. Those abnormal lab results would have required "doctor-to-doctor" consultation, and would have overcome the lack of communications between the surgeon and the nurses. Dr. Singleton also testified the PPM insured anesthesiologist "abandoned" the patient and his negligence was the cause of the patient's death.

The defense anesthesiology standard of care expert testified the standard of care did not require the PPM insured anesthesiologist to order the blood tests in the PACU. He also testified the PPM insured anesthesiologist properly and timely determined that the patient had a surgical complication and requested the nurses to consult with the surgeon to obtain proper surgical interventions.

The PPM insured anesthesiologist also testified in his own defense and explained to the jury he did not order the blood tests because he fully expected them to be abnormal based upon prior test results and due to the patient's prior hospital course. Instead, the PPM insured anesthesiologist's focus was on the spillage of succus, which he initially suspected probably caused chemical irritation and increased tachycardia. He also suspected the patient's high pain levels may have been causing the tachycardia. By switching pain medications to Dilaudid and the administration of a fluid bolus, he thought the patient's pain and tachycardia would be relieved. Since the pain and tachycardia continued, even after the administration of the fluid bolus, the PPM insured anesthesiologist testified it was clear to him this was a surgical complication. He testified further an anesthesiologist has a right to rely on nurses and the surgeon to comply with their own standard of care.

The jury agreed and returned a unanimous defense verdict in favor of the PPM insured anesthesiologist and his anesthesia practice group following a 16-day trial.

The PPM insured anesthesiologist and his anesthesia practice group were represented by Winn Sammons, Esq. and Jim Goodwin, Esq. from Sanders & Parks, PC in Phoenix, Arizona. The file was managed on behalf of PPM by Brian Thomas, Senior Claims Attorney & Director of Risk Management. ❖

Nerve Damage: Georgia Defense Verdict

A Gwinnett County, Georgia jury returned a defense verdict in favor of a PPM insured anesthesiologist and her anesthesia practice group. Plaintiff alleged the PPM policyholder negligently administered an epidural steroid injection causing nerve damage.

The lawsuit involved a 52 year-old female with a history of facial pain due to trauma. The PPM insured anesthesiologist initially diagnosed the patient with trigeminal neuralgia and provided conservative pain management treatment. When conservative treatment failed to provide adequate relief of her symptoms, the patient elected to proceed with an epidural steroid injection.

The PPM insured anesthesiologist discussed the benefits and risks (including paralysis and spinal cord trauma) of the procedure and obtained the patient's written informed consent. Thereafter, the patient was lightly sedated and an epidural steroid injection was administered at level C5-C6 utilizing fluoroscopic guidance. The patient tolerated the procedure well and met all discharge criteria prior to being discharged home. The patient called 911 the following day and was taken to the emergency room complaining of leg weakness and difficulty moving her left arm and hand.

The patient sued the PPM insured anesthesiologist and her anesthesia practice group. Plaintiff alleged the procedure was not medically indicated based upon her symptoms; plaintiff was too deeply sedated to safely perform this procedure; the procedure was negligently performed by injecting into plaintiff's spinal cord; and the PPM insured anesthesiologist failed to determine the location of the needle using lateral fluoroscopy with contrast material.

Prior to trial, plaintiff made a non-negotiable $1.5 million settlement demand. The PPM insured anesthesiologist felt strongly her care and treatment were appropriate. Additionally, PPM and defense counsel secured supportive expert opinions; therefore, the PPM insured anesthesiologist did not consent to settlement and the case was prepared for trial.

Plaintiff's retained anesthesia expert, Dr. Stephen Abram from Neosho, Wisconsin, testified there were 14 deviations from the standard of care committed by the PPM insured anesthesiologist. Dr. Abram's criticisms included performing a procedure that was not medically indicated, overly sedating the patient and performing the injection at a level too high.

The defense pain management expert testified C5-C6 was an appropriate level for the injection. He also supported the PPM insured anesthesiologist's testimony explaining her technique and the use of fluoroscopic guidance. The defense expert noted both the PPM insured anesthesiologist and the assisting nurse testified the patient was awake, alert, talking and squeezing their hands during the procedure. He testified further hitting the spinal cord was a known risk of the procedure whether it was the first needle (local anesthetic) or the second needle (epidural steroid injection).

During closing arguments plaintiff's counsel asked the jury to award plaintiff $5.8 million. Following an eight-day trial, the jury deliberated approximately nine hours before returning a defense verdict in favor of the PPM insured anesthesiologist and her anesthesia practice group.

The PPM insured anesthesiologist and her anesthesia practice group were represented by Wade Copeland, Esq. of Carlock, Copeland & Stair LLP, Atlanta, Georgia. The file was managed on behalf of PPM by Wade D. Willard, Vice President-Claims. ❖

Cardiac Arrest: New York Defense Verdict

A Suffolk County, New York jury returned a defense verdict in favor of a PPM insured anesthesiologist in a lawsuit stemming from a known risk and complication that was treated appropriately. Plaintiff's global settlement demand prior to trial was $450,000. The PPM insured anesthesiologist was committed to defending his care and no settlement offer was made to plaintiff. The hospital settled for $10,000. The case proceeded to trial against the PPM insured anesthesiologist.

The lawsuit involved a 54 year-old female who presented for shoulder arthroscopy. The anesthetic plan was to administer an interscalene block pre-operatively for post-operative pain management. After appropriate informed consent was obtained, the patient was sedated and a nerve stimulator was used to determine correct placement of the needle. After injecting 25 mls in 5 ml increments, a tinge of blood in the syringe was noted. The PPM insured anesthesiologist cleared the needle and aspirated again. Blood was noted again so the needle was removed and the

block aborted. Approximately 10 seconds later the patient seized and went into cardiac arrest. Full resuscitative measures were undertaken including ACLS medications, intubation, and placement of central venous pressure and arterial lines. The patient was successfully resuscitated and received consults from cardiology, pulmonology, and internal medicine. The patient subsequently developed an infection at the arterial line site that was treated with antibiotics. Cardiac tests showed suspected heart scarring, which was later ruled out.

The patient sued the PPM insured anesthesiologist and the hospital. The allegations against the PPM insured anesthesiologist were failure to inject a test dose prior to the administration of the block and failure to wait 30 to 60 seconds between injection and the next aspiration. Plaintiff alleged the attempted administration of the interscalene block was below the standard of care and resulted in her sustaining a cardiac arrest due to an arterial injection of Marcaine. She claimed permanent damage to her wrist from the arterial line site infection and heart. Plaintiff also claimed she suffered from anxiety as a result of the cardiac arrest.

Plaintiff's retained anesthesia expert, Dr. Alexander Weingarten, from New York, testified the PPM insured anesthesiologist departed from the standard of care by failing to administer a test dose prior to commencing the injections of Marcaine and by failing to wait 30 to 60 seconds between each injection. Dr. Weingarten conceded there was no evidence of permanent cardiac damage and all objective tests performed on plaintiff's wrist showed no permanent damage.

The defense standard of care expert testified a test dose was optional and not the standard of care. He also testified it was not the standard of care to wait 30 to 60 seconds between injections.

Following a one-week trial, plaintiff asked the jury to award $600,000 in damages. The jury returned a defense verdict in favor of the PPM insured anesthesiologist after deliberating approximately one hour and forty-five minutes.

The PPM insured anesthesiologist was represented by Bruce Brady from Callan, Koster, Brady & Brennan, LLP, New York, New York. The file was managed on behalf of PPM by Shelley Strome, Senior Claims Specialist. ❖

Nerve Damage: New York Defense Verdict

A Dutchess County, New York jury returned a unanimous defense verdict in favor of a PPM insured anesthesiologist following an eleven-day trial.

The lawsuit involved a 38 year-old female who presented for a left shoulder acromioplasty under general anesthesia via LMA with an interscalene block for post-operative pain management. The plaintiff's history was significant for a fractured clavicle sustained during a motor vehicle accident two years prior. She underwent surgery shortly after the motor vehicle accident followed by conservative management for pain; however, she continued to complain of pain and reduced range of motion. Her orthopedic surgeon recommended a resection of the left clavicle to promote increased range of motion. Informed consent for general anesthesia and the interscalene block was obtained by the PPM insured anesthesiologist. The plaintiff was placed in the "beach chair" position for the fifty minute procedure that was performed without apparent complications. In recovery, the plaintiff complained of numbness in the left side of her face, neck and shoulder.

The plaintiff continued to complain of numbness in her left cheek, neck and shoulder after the effects of the block wore off. She began treating with neurologists who diagnosed the plaintiff with a left sensory neuropathy of part of the maxillary branch and the entire mandibular branch of the trigeminal nerve.

The plaintiff filed suit against the orthopedic surgeon, the PPM insured anesthesiologist and the surgery center. The plaintiff's allegations against the PPM insured anesthesiologist included: 1) negligently performing the interscalene block; and 2) negligently positioning and padding the plaintiff's head for the procedure. Defense counsel successfully moved for partial summary judgment on the first allegation on the basis that plaintiff had no evidence that the interscalene block caused her injuries. Moreover, plaintiff's own expert opined the positioning and padding alone caused the alleged injury. Consequently, the only allegation remaining against the PPM insured anesthesiologist was negligent positioning and padding.

Plaintiff made no settlement demand prior to trial and all defendants took a no-pay position. The defendants determined a joint defense was the best strategy for several reasons, including the fact that none of the personnel involved in the procedure recalled who positioned and padded the plaintiff for her procedure. Further, there was no indication in the medical records or in their collective recall that positioning and padding were anything but standard for this procedure.

Plaintiff's only retained expert was anesthesiologist Alexander Weingarten, M.D. of Syosset, NY. Dr. Weingarten testified the plaintiff's head was not in the neutral position when the surgery began. He testified further the plaintiff's

head must have moved during the procedure causing trigeminal and cervical nerve issues. He held firm to his opinions despite the fact there was no evidence the plaintiff's head was not in the neutral position at the start of the procedure, or the plaintiff's head had been repositioned during the procedure. On cross-examination, Dr. Weingarten admitted nerve damage can happen in the absence of negligence.

The defense anesthesiology expert testified the plaintiff's head was in the neutral position when the case began because that is the position anesthesiologists strive for at the beginning of a case. He disputed plaintiff's head could have moved during the surgery because if it had, he would have expected the LMA to have become dislodged. He testified further the chin strap was of such light material he did not believe it could have caused long-term problems for the plaintiff.

The PPM insured anesthesiologist testified the plaintiff was in the neutral position at the start of the case. She testified further her primary concern was the plaintiff's airway; however, if the plaintiff had moved from the neutral position she or one of the other surgical team members would have corrected plaintiff's positioning. There was no indication in the medical records the plaintiff had any positioning or padding issues. In fact, the intra-operative record reflected once the head restraint was removed, the "plaintiff was free from injury related to surgical position/procedure."

The jury returned a unanimous defense verdict as to all defendants after deliberating for approximately three hours.

The PPM policyholder was represented by Mae D'Agostino from the law firm of D'Agostino, Krackeler and MacGuire in Albany, NY. The file was managed on behalf of PPM by Tracey Dujakovich, Senior Claims Attorney. ❖

Cardiac Arrest: Rhode Island Defense Verdict

A Providence County, Rhode Island jury returned a unanimous defense verdict in favor of a PPM insured anesthesiologist. Plaintiff demanded $600,000 prior to trial to settle her case. The PPM insured expressed his desire to attempt to resolve the case by settlement. Therefore, PPM extended a "cost of defense" settlement offer to plaintiff. Plaintiff rejected PPM's settlement offer and we proceeded to trial.

The lawsuit involved a 43 year-old female who presented for cystoscopy and bladder biopsy with general anesthesia. Upon induction the patient became hypotensive with no palpable pulse. The PPM insured anesthesiologist administered 1 mg of epinephrine and the patient was successfully resuscitated. The surgeon and PPM insured anesthesiologist elected to complete the procedure. Following the procedure, the patient was treated for pulmonary edema. Tests conducted to determine if the patient had any cardiac problems came back negative.

The patient filed a lawsuit against the PPM insured anesthesiologist alleging he was too aggressive in treating her bradycardia and should have administered atropine instead of epinephrine. The plaintiff also alleged the administration of epinephrine caused pulmonary edema and her subsequent Post Traumatic Stress Disorder (PTSD), which she attributed to her belief that she suffered a cardiac arrest.

Plaintiff's anesthesiology expert, William C. Berger, MD from Mill Valley, California, testified the PPM insured anesthesiologist should have done more than attempt to palpate a pulse in order to assess whether there was adequate blood flow. Dr. Berger testified the tape should have been removed from the patient's eyes to determine if her pupils were dilated or her mouth could have been assessed for capillary refill. Dr. Berger testified if these tests had been performed, the PPM insured anesthesiologist would have determined blood flow was adequate and epinephrine would not have been administered. He testified further atropine was less risky and should have been administered instead. Finally, Dr. Berger testified the administration of the epinephrine caused the patient's pulmonary edema.

Plaintiff also had her treating psychologist testify regarding her alleged PTSD. On cross-examination, plaintiff's treating psychologist conceded the plaintiff's treatment records did not support the necessary criteria for a diagnosis of PTSD.

The defense anesthesiology expert testified if the plaintiff had a pulse it would have been appropriate to administer atropine or a lower dose of epinephrine or both. However, where there was no pulse, epinephrine was the appropriate medication.

Mid-trial plaintiff inquired whether the "cost of defense" settlement offer was still available. After consulting with the PPM insured anesthesiologist, PPM advised plaintiff the previous settlement offer was "off the table." Following an eight-day trial, the jury returned a unanimous defense verdict in favor of the PPM insured.

The PPM insured anesthesiologist was represented by Michael Sarli, Esq. from Gidley, Sarli & Marusak, LLP, Providence, Rhode Island. The file was managed on behalf of PPM by Shelley Strome, Senior Claims Specialist. ❖

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