

ANESTHESIA & THE LAW

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*“During closing
arguments, plaintiffs’
counsel asked the jury
to return an award in
the amount of
\$25,000,000”*



FROM THE L&D FLOOR TO THE COURTHOUSE DOOR: Lessons from OB Anesthesia Claims

Introduction

Obstetric anesthesia presents unique professional liability risks because routine labor and delivery care can quickly evolve into a clinical emergency. When an adverse outcome occurs, the anesthesia professionals’ medical judgment, communication, documentation, staffing, and response to changing patient conditions may all become the focus of litigation.

The following case studies illustrate how catastrophic maternal complications, disputed causation, communication breakdowns, and limited anesthesia resources can affect the defense and resolution of obstetric anesthesia claims. This issue also examines inadequately treated pain during cesarean delivery and discusses practical strategies for recognizing, assessing, and responding to intraoperative pain.



CASE STUDY #1

A 27-year-old gravida five para four at more than 41 weeks' gestation, presented to the hospital for induction of labor. She progressed slowly and subsequently developed repetitive severe fetal heart rate decelerations. Because of non-reassuring fetal status, an emergency cesarean section was recommended.

The patient's preoperative history was notable for asthma, cigarette smoking, and thrombocytopenia, with a platelet count of approximately 85,000. Because of the low platelet count, neuraxial anesthesia was considered contraindicated and general anesthesia was selected if operative delivery became necessary. When the fetal heart tracing became increasingly concerning, an emergent cesarean section was undertaken under general anesthesia by the PPM insured anesthesiologist and CRNA.

Induction and delivery proceeded without difficulty. The infant was delivered approximately six minutes after incision and was noted to have a tight nuchal cord wrapped twice around the neck. Despite the fetal distress, Apgar scores were favorable and the newborn appeared to do well. Shortly after delivery, however, the case became significantly more complicated when excessive bleeding was encountered during closure.

The timing and availability of blood products became a major issue throughout the litigation. According to the anesthesia team, blood was requested urgently and repeatedly, yet significant delays occurred before products arrived in the labor and delivery operating room. The anesthesiologist testified that he requested that blood be typed and crossmatched and directed the blood bank to stay several units ahead of anticipated need. He further testified that repeated requests were made when blood failed to arrive as quickly as expected.

Hospital personnel, however, offered different accounts regarding the ordering and delivery process. Nurses and blood bank personnel testified that only single-unit requests were received and that blood was released consistent with normal procedures. The discrepancy created a secondary dispute regarding whether the anesthesia team was hindered by system failures outside its control or whether more aggressive requests for blood products could have been made.

The first unit of blood arrived approximately one hour after the bleeding problem was recognized, followed by additional units thereafter. During this interval, crystalloid fluids, colloid solutions, vasopressors, and transfusions were administered as products became available.



The obstetrical surgeon had inadvertently transected uterine vessels during the procedure. Estimated blood loss varied among providers from approximately 2,400 to 3,000 mL. Although the vessel injury was reportedly repaired surgically, the substantial blood loss prompted the anesthesia team to request blood products and begin aggressive fluid resuscitation.

As the surgical procedure concluded, the patient demonstrated spontaneous ventilation and emerged from anesthesia. She was extubated and transferred to the intensive care unit. At the time of transfer, her blood pressure remained lower than normal but, according to the anesthesia team, it had been stable for the preceding period and was consistent with the clinical picture they were observing.

Plaintiffs later focused heavily on this decision. They alleged that the patient remained unstable, continued to show concerning hemodynamic parameters, and should not have been extubated or transferred from the operating room. They further alleged that intraoperative laboratory testing should have been obtained and that placement of an arterial line or central venous access would have assisted in identifying the severity of her condition and guiding

resuscitation efforts.

The anesthesia team disagreed. The anesthesiologist testified that laboratory testing would not have altered management because the team was already actively replacing blood loss and administering all available blood products. The CRNA similarly testified that laboratory values would not have changed their

immediate treatment course. The defense also emphasized that critical care physicians, who assumed care in the ICU, voiced no criticisms of anesthesia management and believed earlier arterial blood gases, intubation, or invasive monitoring would not have changed the outcome.

The plaintiff's expert anesthesiologist argued that the anesthesia team failed to appreciate the magnitude of blood loss, failed to order appropriate laboratory testing, did not adequately resuscitate the patient with blood products, transferred her to the ICU while unstable, and extubated her prematurely. According to this opinion, hemorrhagic shock led to coagulopathy, DIC, cardiac arrest, and death.

The independent pathologist retained by the plaintiff also concluded that excessive blood loss caused the death. He believed that a young and otherwise healthy woman should have survived the vascular injury had adequate blood and fluid replacement been provided. He rejected alternative explanations such as amniotic fluid embolism and testified that hemorrhage was the primary and undisputed cause of death.

Plaintiffs alleged specifically that the anesthesia providers failed to:

- Recognize excessive blood loss and hypovolemic shock.
- Obtain appropriate intraoperative laboratory studies.
- Administer sufficient blood products.
- Maintain appropriate monitoring and resuscitation.
- Keep the patient intubated.
- Delay transfer until physiologic stability was achieved.

These allegations reflected a classic hindsight-biased resuscitation case. Looking back from the known outcome, plaintiffs argued that every opportunity to escalate care should have been utilized sooner.

The defense countered with a markedly different explanation. Highly credentialed obstetrical anesthesia, obstetrical, and pathology experts opined that the patient suffered from amniotic fluid embolism, a rare obstetrical catastrophe characterized by cardiovascular collapse, coagulopathy, and disseminated intravascular coagulation.

The defense experts emphasized several features they believed supported AFE:

- Preexisting thrombocytopenia.
- Development of severe DIC.
- Clinical deterioration out of proportion to treated blood loss.
- Acceptable hemoglobin levels following transfusion.
- Lack of evidence that hemorrhage alone could explain the physiologic collapse.
- The recognized difficulty of confirming or excluding AFE through autopsy findings alone.

Defense experts testified that AFE is primarily a clinical diagnosis. They described it less as a true embolic event and more as an anaphylactoid or inflammatory reaction occurring during labor and delivery. According to their opinions, the patient's coagulopathy and circulatory collapse were more consistent with AFE than with untreated hemorrhagic shock.

The defense also highlighted testimony from treating physicians, including the obstetrical surgeon and the intensivist, both of whom had no criticisms of the anesthesia team's actions. Several treating physicians believed AFE was the most likely diagnosis from the outset.

One of the most interesting aspects of the case was the distinction between causation and standard of care. Even reviewers supportive of the anesthesia team acknowledged several management decisions that could be questioned, including the absence of invasive monitoring, lack of intraoperative laboratory studies, and the decision to extubate. A medical consultant retained during the defense review noted that an arterial line, coagulation studies, and continued postoperative ventilation could have been beneficial.

Yet the central legal issue remained whether any such shortcomings caused the patient's death.

This distinction is frequently critical in anesthesia negligence litigation. A plaintiff must establish not only that additional measures could have been taken, but also that those measures would more likely than not have altered the outcome. Here, the defense argued that even if different management choices had been made, they would not have prevented death because the underlying condition was AFE rather than inadequately treated hemorrhage.

Prior to trial, the hospital and related co-defendants resolved the claims against them through settlement. Plaintiff's pre-trial settlement demand to the anesthesia defendants was \$3,000,000. The case proceeded to trial against the PPM insured anesthesiologist, CRNA, and their anesthesia practice. During closing arguments, plaintiffs' counsel asked the jury to return an award in the amount of \$25,000,000. Following an eight-day trial in St. Louis City, Missouri, the jury returned a 9-3 defense verdict in favor of the anesthesia defendants.

KEY TAKEAWAYS

The verdict reflected the jury's acceptance of the defense position that the anesthesia team had responded appropriately to a rapidly evolving obstetrical emergency and that the plaintiffs failed to establish that any alleged departures from the standard of care caused the patient's death.

This case study illustrates the complexity of malpractice litigation involving catastrophic obstetrical events. Plaintiffs argued that the anesthesia team failed to adequately recognize

and manage hemorrhagic shock resulting from surgical vascular injury. The defense countered that the anesthesiologist and CRNA responded appropriately to a crisis complicated by delayed availability of blood products and that the patient's deterioration was more consistent with amniotic fluid embolism and disseminated intravascular coagulation than with inadequately treated blood loss. Experts on both sides presented sharply conflicting opinions regarding causation, resuscitation, monitoring, and postoperative management.

The case also demonstrates that unfavorable outcomes alone do not establish negligence. Although the death of a young mother of five inevitably generated significant sympathy, the jury

was persuaded that the evidence did not support liability against the anesthesia providers. After the hospital settled before trial, the claims against the anesthesia defendants were fully tried before a jury, which returned a 9-3 defense verdict following eight days of testimony. The result underscores a principle that frequently arises in anesthesia malpractice cases: when multiple plausible causes exist for a patient's injury or death, establishing causation may be far more difficult than identifying potential criticisms of care. For anesthesia professionals, the case serves as a reminder of the importance of crisis management, documentation, interdisciplinary communication, and the ability to explain complex causation issues to a jury long after the clinical event has occurred.



CASE STUDY #2

A 40-year-old patient presented for induction of labor. The patient was noted to have polyhydramnios, but her pregnancy was otherwise uneventful. After rupture of membranes, the obstetrician (OB) identified an abnormal fetal presentation, which later progressed to an umbilical cord prolapse requiring an emergency cesarean delivery (C-section). The OB directed the charge nurse to contact anesthesia and ask them to respond for a "Priority 1" emergency C-section due to umbilical cord prolapse.

The labor and delivery team contacted the on-call anesthesiologist, who was medically directing two CRNAs in the main OR suite. When he received the call, the anesthesiologist was helping one of the CRNAs manage a patient who had experienced respiratory depression. He immediately contacted the backup anesthesiologist and asked him to respond to the hospital. The backup anesthesiologist indicated he would be there in 20 minutes. The charge nurse contacted the on-call anesthesiologist a second time approximately 10 minutes after the emergency C-section was initially called, and he informed her that an anesthesiologist would arrive in a few minutes. However, the obstetric team determined that fetal compromise required immediate surgical intervention, and the OB proceeded with the C-section under local anesthetic. The patient remained awake during the initial portions of surgery, experiencing significant pain and distress. Shortly after the infant was delivered, both anesthesiologists responded to the room within a minute of each other. They quickly induced general anesthesia, and the OB

completed the procedure. The infant's APGAR scores were within normal ranges, and the patient did not sustain physical injuries during labor or the C-section. However, she later reported developing severe emotional trauma and post-traumatic stress disorder (PTSD) as a result of undergoing the C-section without adequate anesthesia.

"[T]he patient did not sustain physical injuries during labor or the C-section. However, she later reported developing severe emotional trauma and post-traumatic stress disorder (PTSD) as a result of undergoing the C-section without adequate anesthesia"

The patient filed a lawsuit against the on-call anesthesiologist, his anesthesia practice group, and the facility. During litigation, the plaintiff attorney focused on communication, staffing expectations, and emergency response rather than technical anesthetic management. At her deposition, the charge nurse

testified she specifically mentioned to the anesthesiologist that the OB had called for a "Priority 1" C-section due to cord prolapse. However, the anesthesiologist maintained he was advised only that an emergency C-section was called, and it was his understanding that he had 30 minutes to respond. This was an important distinction because the hospital's "Cesarean Section Protocol"* states anesthesiologists should respond immediately for "Priority 1" emergency C-sections, while they are expected to respond to the OR within 30 minutes when a "Priority 2" emergency C-section is called. The charge nurse's testimony was corroborated by the labor & delivery nurse assigned to the patient's room, and the OB testified she was not present when the charge nurse contacted the anesthesiologist.

Based on the testimony of the nurses, plaintiff's experts criticized the anesthesiologist for failing to immediately respond to the emergent C-section, or in the alternative, direct a CRNA to respond to the obstetric unit while he managed the CRNA's patient in the main OR suite. Defense experts contended the anesthesiologist acted reasonably based on the facility's staffing model and information that was relayed by the obstetric care team. Defense experts also emphasized multiple missed opportunities for earlier communication from the obstetric care team to anesthesia. Notwithstanding defense experts' support, the case would be challenging to defend through trial since plaintiff had clearly established there was a breakdown in communication between the charge nurse and the anesthesiologist. This would assuredly turn the case into a

"This case illustrates that obstetrical anesthesia claims frequently arise not from technical errors, but from communication failures, resource limitations, and differing perceptions of urgency during rapidly evolving clinical emergencies"

CESAREAN SECTION PROTOCOL*

Purpose: To list responsibilities during a Cesarean Section and to ensure use of an institutional common terminology for the timeliness of cesarean sections with documentation

Priority One: The attending obstetrician or charge nurse will notify the Charge Anesthesiologist that a Priority One C-Section needs to be done immediately. Some examples:

1. Severe fetal bradycardia
2. Suspected Placental abruption
3. Suspected uterine rupture
4. Prolapsed umbilical cord

Priority Two: The attending obstetrician or charge nurse will notify the Charge Anesthesiologist that a Priority Two C-Section needs to be done in 30 minutes or less. Some examples:

1. Concerning fetal hear rate pattern
2. Malpresentation in active labor

question of the co-defendants' credibility and create the appearance of "finger-pointing," and leave a jury with the impression that one or more defendants were at fault for failing to follow the hospital's protocol. Accordingly, the anesthesiologist consented to settlement at the conclusion of discovery.

The parties subsequently mediated the case, and the anesthesia defendants and the facility reached confidential settlement agreements with the plaintiff. PPM contributed a mid-six figure amount to resolve all claims against our insureds.

This case illustrates that obstetrical anesthesia claims frequently arise not from technical errors, but from communication failures, resource limitations, and differing perceptions of urgency during rapidly evolving clinical emergencies. Documentation gaps and conflicting witness testimony can significantly impair the defensibility of a case even when experts are otherwise supportive of the anesthesia professional's care.

In obstetrical anesthesia litigation, communication failures are often more difficult to defend than clinical judgment decisions. Standardized emergency terminology, closed-loop communication, adequate staffing contingency plans, and contemporaneous documentation can substantially improve both patient safety and claim defensibility.



RISK MANAGEMENT ANALYSIS

1. Establish Clear Emergency Cesarean Communication Standards

When an emergency designation is used, there should be no ambiguity regarding the urgency of anesthesia involvement. Facilities should adopt standardized language for obstetrical emergencies to ensure all members of the OB, nursing, and anesthesia teams understand the expected response associated with each designation.

2. Implement Backup Coverage Plans When Feasible

Plaintiff attorneys commonly scrutinize staffing adequacy following an adverse outcome. Hospitals providing obstetrical services should periodically evaluate anesthesia staffing models to ensure they can appropriately respond when an anesthesia professional is occupied with patient care responsibilities elsewhere in the facility and unavailable. Depending on hospital capacity and resources, facilities might consider adopting:

- Secondary call systems
- Cross-coverage arrangements
- Escalation protocols for simultaneous emergencies
- Defined contingencies when anesthesiology resources are limited

3. Use Closed-Loop Communication

Closed-loop communication helps ensure that all parties share the same understanding of the situation and reduces later disputes regarding what information was exchanged. During obstetrical emergencies:

- The caller should clearly state the emergency level
- The receiving provider should repeat back the information
- Expected arrival times should be communicated
- Changes in patient status should be immediately relayed

4. Document Significant Communications

Contemporaneous documentation often becomes critical when recollections differ years later during litigation. When emergency response decisions are influenced by information received from another clinician or nurse, documentation should capture:

- Who communicated the information
- What was communicated
- Time of communication
- Actions taken in response

5. Conduct Multidisciplinary Debriefs

Structured multidisciplinary debriefings following obstetrical emergencies can help clinicians identify systems issues, communication breakdowns, and opportunities for process improvement before they contribute to future adverse events.



Use This QR Code to View a Recording
of Dr. Nixon's Presentation at the
2025 APSF Stoelting Conference

Pain Control During Cesarean Delivery: Patient Safety Strategies from the 2025 APSF Stoelting Conference

Pain Management During Cesarean: Inadequately Treated Pain presented by Heather Nixon, MD at the 2025 APSF Stoelting Conference focuses on intraoperative pain during cesarean delivery as a significant and often underrecognized patient safety issue. Dr. Nixon encourages anesthesia professionals to regard inadequately treated pain during cesarean section as a form of preventable harm that can result in long-term psychological and physical consequences, including post-traumatic stress disorder (PTSD), impaired maternal-infant bonding, and breastfeeding difficulties.¹

Key Patient Safety Takeaways

1. Recognize Intraoperative Pain as a Patient Safety Event

A central theme of the presentation is that pain experienced during cesarean delivery should not be normalized or dismissed. Patients may experience significant visceral pain despite appearing to have an adequate neuraxial block based on traditional sensory testing. Failure to recognize and address this pain can result in substantial patient harm.

2. Avoid Misattributing Pain to Anxiety

The speaker notes that clinicians may incorrectly characterize a patient's pain as anxiety, nervousness, or expected pressure. This cognitive bias can delay appropriate treatment and leave patients feeling unheard or disbelieved. Risk management begins with taking reports of pain seriously and validating the patient's experience.

3. Understand the Limitations of Traditional Testing

Standard skin-prick or sensory testing evaluates somatic pain pathways but may not predict whether visceral pain from uterine or abdominal manipulation is adequately blocked. Providers should recognize that a technically successful block does not guarantee a pain-free surgical experience.



Risk Management Strategies

1. Discuss Pain Expectations with Patients Preoperatively

Patients should be informed before surgery that intraoperative pain is possible and should be encouraged to report discomfort immediately. Setting expectations and discussing available interventions promotes informed consent and shared decision-making.

2. Establish a Standardized Response Protocol

When feasible, coordinate with obstetric departments and facilities to develop patient safety bundles that include clear institutional procedures for assessing and managing pain during cesarean delivery. Standardization reduces variability in care and supports timely intervention when pain occurs.

3. Use Effective Adjunctive Analgesic Strategies

Anesthesia teams should be familiar with adjunct medications and techniques that can improve block quality and reduce the likelihood of breakthrough pain. Proactive management is preferable to reacting to symptoms after severe pain develops.

4. Improve Team Communication

Anesthesiologists, obstetricians, nurses, and other team members should communicate proactively regarding anticipated painful portions of the procedure. Advance warning allows the anesthesia team to prepare interventions before the patient experiences significant discomfort.

5. Create a Culture That Prioritizes Maternal Comfort

Challenge the longstanding culture of minimizing maternal pain with phrases such as "it's just pressure" or "it's almost over." Patient-centered care requires acknowledging pain, responding promptly, and avoiding language that discourages patients from advocating for themselves.

6. Escalate Care When Necessary

Stop and reassess when meaningful pain is reported rather than attempting to "push through" the procedure. Providers should be willing to escalate analgesic interventions or convert to general anesthesia when patient comfort and safety require it. Fear of conversion should not supersede patient welfare.

References

¹Reproduced and modified with permission from the APSF. Heather Nixon, MD. Pain Management During Cesarean: Inadequately Treated Pain. APSF Stoelting Conference Transforming Maternal Care: Innovations and Collaborations to Reduce Morbidity and Mortality. 2025. Accessed September 17, 2026. <https://www.apsf.org/presentation/pain-management-during-cesarean-inadequately-treated-pain/>

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ANESTHESIA & THE LAW

A Risk Management Newsletter

**IN THIS ISSUE**

Obstetric anesthesia presents a distinctive risk environment in which routine care can become an emergency within moments. In this issue, we examine two claims involving emergency cesarean deliveries and the difficult clinical, communication, and operational challenges that followed. The first case resulted in the death of a young mother following significant intraoperative bleeding and a disputed diagnosis of hemorrhagic shock versus amniotic fluid embolism. The second involved a patient who underwent an emergency cesarean delivery under local anesthesia after communication and staffing issues delayed the anesthesia response.

We also review patient safety guidance from the Anesthesia Patient Safety Foundation concerning inadequately treated pain during cesarean delivery and discuss practical strategies for recognizing, assessing, and responding to intraoperative pain.

Together, these examples highlight the importance of emergency preparedness, closed-loop communication, careful documentation, patient-centered pain management, and coordinated follow-up in reducing patient harm and improving claim defensibility.

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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