MALPRACTICE CONSULTING: LESSONS LEARNED

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Conflicts of interest

- Consulting for various defense and plaintiff attorneys
- Spouse owns stock in Amgen, Abbott, Abbvie
#1 Lesson learned?

When she is arresting from a high spinal, *SHE IS PROBABLY HYPOTENSIVE*
What does not get you sued?
Components of Medical Malpractice

- Doctor/CRNA-patient relationship
- Injury/loss
- Breach of “standard of care”
- Breach led to or contributed directly to injury

Components of Medical Malpractice

- Breach of “standard of care”
  - Who decides?
    - People like me tell juries
  - Consistent with “good and accepted practice”
    - “reasonable and prudent practitioner”
    - “what a majority of physicians…”
    - “respectable minority”
    - Guidelines/standards
Components of Medical Malpractice

- Breach led to or contributed directly to injury
  - Often clear, SOMETIMES not
What does not get you sued?
At a routine elective CS is it within the SOC to perform a spinal anesthetic and take maternal blood pressure every 5 minutes?

(as opposed to q1, 2, 2.5?)
SOC example

If the anesthesia record (paper chart) notes 4 separate doses of phenylephrine (total 450 mcg) and 3 doses of ephedrine (total 25 mg) between 1000 and 1005, is it OK to only take maternal BP at 1000 and 1005?
Burden of proof

- These are CIVIL cases
  - No “guilt,” only liability
  - Need 5-1 verdict, or 10-2

The 50.00001% questions?

“Is it more probable than not that the anesthesiologist’s actions caused this?”

“Is this the most likely cause of the injury?”
It’s not all bad news... even in the USA
PROFESSIONAL LIABILITY TRENDS IN 2016:
Things Are Stable, But Changes May Be Lurking

Christopher M. Burkle, M.D., J.D., Chair
Committee on Professional Liability

Figure 2: Average Premiums for Mature $1M/$3M Policy Limits:
Surgical Anesthesia vs. Pain Management

ASA Monitor. 2017;81(2):12
My history

- First review 1998
- ~ 350 cases reviewed
- ~ 70% defense/30% plaintiff
- ~ 26 depositions (10 defense, 17 plaintiff)
- 11 trials/panels (5 defense, 6 plaintiff)
- 1 “mock trial” (defense)
- 1 case as DEFENDANT (settled)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Plaintiff (40)</th>
<th>Defense (38)</th>
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<tbody>
<tr>
<td>neonatal injury (HIE)</td>
<td>10</td>
<td>8</td>
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<tr>
<td>Maternal nerve injury</td>
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<td>3</td>
</tr>
<tr>
<td>Cardiac arrest or high spinal</td>
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<td>5</td>
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<tr>
<td>Hemorrhage</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anesthesia delay for CS</td>
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</tr>
<tr>
<td>Catheter technical issue</td>
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<td>CS airway catastrophe</td>
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<td>1</td>
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<tr>
<td>Other maternal injury</td>
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<tr>
<td>Non-OB</td>
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What don’t I see? (much)

- Consent issues (NOT ONE)
- Sick, “complex” patients
- Epidural hematoma/epidural abscess
  - One recent court case, and my one case
- Pain during CS
  - Now seen 2
  - failed epidural or late-arriving anesthesiologist
- Drug error
  - at least not a known error
- 360 cases over 21 years (database)
- Commonest OB anaesth claim in UK
  - 31% of OB regional anaesth complaints
- OB anesth 2000-2010: £19M
Anesthesia delay ("stat" CS)
Anesthesiologist is in the lawsuit for a brain-injured (hypoxic encephalopathy) because the obstetricians state that they wanted to do a “Super-stat” CS and he said he needed to wait for 10 minutes to fluid load, then do a spinal…”

(circa 2003)
Defense case—"anesthesia delay"

- RN note: 1715, called anesthesia for urgent intrapartum CD
- 1728: Anesthesia with pt
- 1734: in OR
- 1735-45: 1 liter RL given
- 1747: spinal in
Can I help? What did I say?

- No issues with actual anesthesia care
- Spinal 1747
- Time of incision 1759
- Time of delivery 1810

My opinion (And probably yours): At the time of CS, there was NO SENSE of “super-urgency” otherwise incision and delivery would have been MUCH earlier

⇒⇒anesthesiologist dropped from case
Anesthesia delay?—Community hospital obstetrics

- CS called for VERY bad tracing 1021
  - RN noted brady at 1009
  - Ob note/called CS at 1021
  - ? When anesth called
- Anesthesiologist arrives 1106, spends 9-12 minutes with pt in LDR getting consent before going to OR
- In OR 1118, baby delivered 1121
  - Apgars 1,3
  - pH 6.89
Anesthesia delay?—Community hospital obstetrics

My opinions:

1. SOMEONE probably did something wrong. Will need testimony about chain of events (who told who what, when).

2. Not COMPLETELY clear injury was preventable in this context

3. If the anesthesiologist was told this was truly “STAT” (with appropriate explanation of why), 9-12 minutes sitting in patient room talking is too long.

4. Even IF “anesthesia delay” --- causation is another issue
Do the right thing
(esp. when the story is a little unusual?)

i.e., what would YOU want YOUR anesthesiologist to do?
Do the right thing?

- Elective repeat CS

- Husband and pt state “our main concern is a high spinal; she had one last time, they rushed him [the husband] out of the OR, she spent 2 days in ICU…”

- Previous CS was at “sister” hospital 2 years prior
Do the right thing--2

- Does the SOC require anesthesiologist need to obtain (or try to obtain) old records?

- Anesthesia plan

- Performance of anesthetic
Do the right thing--3

- No attempt to obtain old record/contact prior hospital
- Husband and surgeon testify that anesthesiologist said “don’t worry, I will give you a half dose”
- 2.3 ml isobaric bupivacaine (11.5 mg) given (w morphine and fentanyl)

IS THIS WITHIN SOC?
Do the right thing--4

- 1-2 min post-spinal pt flailing arms, agitated
- Attempted intubation—difficult
- Glidescope obtained
- Intubated (~ 7 minutes?)
- No vasopressors until intubation, then epi 500 mcg
- No BP recorded during arrest/high spinal
- Lowest SBP on (paper) chart 80/45

IS THIS WITHIN SOC?
High spinals—3 VERY similar cases (lying may not help)

- Arrest during CS under spinal anesthesia
- 2 doses epinephrine given
  - ± defibrillation shock
- “Rapid recovery”
- Significant or fatal HIE
- NO SBP on paper chart < 90 mm Hg
SIMPLE documentation...
Document the “little” bad stuff

- Plaintiffs lawyer calls with case of obese woman with probable L3 nerve injury from labor epidural procedure
- Patient says anesthesiologist persisted “forever” although she complained of intense, repeated pain RLE
- Anesthesia record: “epidural placed L3-4, no complications”
- Nurses notes: “time out 1621...epidural test dose 1732..”
“note”able case

- Complaint of neurologic injury (radiculopathies) post-epidural analgesia
- Patient had had motorcycle accident 3 years before with MULTIPLE disc bulges and a fracture in lumbar spine
- Had been in PT for over a year post-accident
- Complaint now very vague, very similar to complaints in past after accident

BUT.....
Epidural placed 2AM, 2-3 attempts, moderate diff, decent analgesia.

Multiple top ups 5AM-8AM

Replaced (according to nurses notes) 9AM by new attending—NO NOTE WHATSOEVER

Is this OK? Is this negligence? Will this change the outcome of a lawsuit?
Settled

- not my advice, but I do not know any law, nor do I know the defendants
And there's some BAD stuff done (or not done)…
Tachycardia

- CS, some atony, methergonovine given, est 1200 ml blood loss. Last vitals (recorded) in CS: HR 90, BP 110/74

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<tr>
<td>1400</td>
<td>133</td>
<td></td>
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<tr>
<td>1405</td>
<td>132</td>
<td>85/37</td>
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<tr>
<td>1420</td>
<td>135</td>
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<td>142</td>
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<tr>
<td>1445</td>
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<tr>
<td>1450</td>
<td>161</td>
<td>64/44</td>
</tr>
<tr>
<td>1453</td>
<td>144</td>
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</tr>
<tr>
<td>1502</td>
<td>No IV?</td>
<td></td>
</tr>
<tr>
<td>1504</td>
<td>arrest</td>
<td></td>
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Recent case (court testimony)

- 23 year old, morbidly obese, NSVD 2AM
- Methylergonovine given, EBL 800
- Fluids LR 125/hr
- 2AM-4AM nursing notes: “continuous bleeding, moderate/heavy”
- PT HR 112—126—134—142
- OB sees pt at 4AM
  - NO VS (SBP was 90s)
  - Hemabate given
  - ? Vaginal exam
  - No fluid order
  - CBC @ 6AM
Recent case (court testimony)

- 5AM HR 155, BP 90/40, SpO2 92
- 540AM HR 160, blood draw done, OB called
- Arrest as OB arrives (more or less)
- Hg 6.3

Dx: uterine inversion
Defense: TTP (???????)
Verdict: ~ $7M
2nd “lesson learned” (I REALLY hope you know this already)

**TACHYCARDIA** is Hemorrhage

Tachycardia **IS** Hemorrhage

Tachycardia is **HEMORRHAGE**

Of course, sometimes it’s something else, but even when you think it is something else, it is probably hemorrhage
Hemorrhage—whose “fault?”

- CS, moderately excessive bleeding, probably atony
- Anesthesiologist starts 2\textsuperscript{nd} and 3\textsuperscript{rd} IV
- Pt awake, alert
- 3U PRBCs given 3.5 L RL
- EBL 3000
- OB says not bleeding now, might want to take pt to IR; pt prepared for transport
- BP $\downarrow$, back to OR table, GA induced
- Abdomen opened 10 min later, arrest
Hemorrhage—a few observations

- Difficult to assess timing
- Frequently at least “defensible” for anesthesiologist
- Defense attorneys want it to be AFE
- Documentation helps, but difficult (but the defense expert KNOWS that)
- Don’t start a probable accreta on a Saturday as the only anesthesiologist in house with a 20G IV (yes, it happened)
Lesson #3?

We do not document things well in the PACU

Even whether we are THERE or not
Assorted defense cases (defensible)

- Sudden gasping, hypotension during labor—death after 3 hours in OR (AFE)
- Similar case during VTOP
- Several hemorrhage cases
- Pregnant woman in MVA, hosp with no OB, then to OB hosp, cord prolapse?, 35 min until OR, diff starting IV
- Multiple "bad babies" not due to anesthesia
- Man claimed herpes infection (oral) and impotence after penile implant, due to conversion of spinal anesthesia to general!
Plaintiff cases not going forward after talking with me

- Lip/pharyngeal injury during intubation
- LE pain after epidural (2)
- PDPH
- Back pain after epidurals...
- 2 probable AFEs (hemorrhage, low fibrinogen early or sudden CV collapse)
Sometimes you just don’t know what the heck...(2 fairly similar cases in New York)

- Apparently routine spinal for elective CS
- No LE motor recovery for 72h, very slow afterward
  - Still can’t walk at 23 months

- NEGATIVE IMAGING, NO DIAGNOSIS OR EVEN THEORY BY PRACTITIONERS AT THE TIME OR SUBSEQUENT CONSULTANTS
And sometimes you can’t win

- 2 cases, similar... (NY, New Hampshire)
- Severe PEC, questionably developing cerebral signs
- To imaging/MRI first, or CS first?
Summation

- The system IS unfair and inefficient (but not quite as bad as some think)
- Some kind “no-fault” for neonatal or other catastrophic injuries MIGHT make sense (but remember, this is the USA)
- Staying completely objective as an expert is essential...but difficult
  - I try
- Some people are REALLY hurt by BAD doctors
- Documentation helps
Another useful lesson

There is injustice in the world, but unfair malpractice judgements against physicians who are insured do not come close to the top of the list...
Matter of opinion I guess...
The devil is in the details

- 27 year old achondroplastic dwarf
- Proper pre-op consultation
  - Plan --- attempt epidural for CS
  - GA if unsuccessful
- Patient arrives, SROM, mild contractions
- No OB in hospital
The devil is in the details

- Epidural attempted in labor room
  - Several (3-4?) attempts
  - LOR—catheter will not thread
- 1734: 3 ml 2% lidocaine with epi via needle
  - ? Effect
- 1736: Spinal needle via Tuohy—no CSF, BP 138/72
- 1738: RN note “2nd test dose given”
  - No note of what needle it went or did not go through
- MD DENIES giving 2nd test dose
The devil is in the details -3

- 1739: respiratory arrest
- 1741: to OR, mask ventilation
- 1743: in OR, stat paging OB
  - BP cuff on stat (defendant’s deposition)
  - NO BP recorded until 1758 (p epi)
  - RN note in OR states “patient ventilated but cyanotic/dusky/mottled”
- 1757: epinephrine 500 mcg given
- 1758: BP 90, then 150, then 170
- 1759: CS starts
The devil is in the details-- 3

- Questions for the expert (me)
  - Was there negligence?
  - Epidural with no OB in house negligence?
  - Did anesthesiologist give 2\textsuperscript{nd} “test dose”?
  - Was giving 1 (or 2) “test doses” negligence?
  - Treatment of complication (arrest) negligent?
  - Sufficient to cause injury?

- NOT question for anesthesia expert
  - Evaluate injury
GUIDELINE III

REGIONAL ANESTHESIA SHOULD NOT BE ADMINISTERED UNTIL: 1.) THE PATIENT HAS BEEN EXAMINED BY A QUALIFIED INDIVIDUAL; AND 2) A PHYSICIAN WITH OBSTETRICAL PRIVILEGES TO PERFORM OPERATIVE VAGINAL OR CESAREAN DELIVERY, WHO HAS KNOWLEDGE OF THE MATERNAL AND FETAL STATUS AND THE PROGRESS OF LABOR AND WHO APPROVES THE INITIATION OF LABOR ANESTHESIA, IS READILY AVAILABLE TO SUPERVISE THE LABOR AND MANAGE ANY OBSTETRIC COMPLICATIONS THAT MAY ARISE.

Under circumstances defined by department protocol, qualified personnel may perform the initial pelvic examination. The physician responsible for the patient's obstetrical care should be informed of her status so that a decision can be made regarding present risk and further management.
Verdict—DEFENSE

- Defendants verdict
- 3 of 6 jurors told plaintiffs attorney “we did not think he did it on purpose”
- Unclear if plaintiffs injury was convincing
- Locale more favorable to defense?
  - Southern United States
The comment regarding the view of many in academic centers of dosing through the Tuohy needle as malpractice, has unfortunately been true in my experience as well. In fact such a claim was made in a case for which I served for the defense very recently. The holder of that view on behalf of the plaintiff’s attorney was a well-known anesthesiologist at a major teaching institution. Yet such a view is not supported by published evidence and should be abandoned. Such “expert” opinion should never be accepted without such evidence. Indeed, if one goes back far enough in the literature, one finds eminent obstetric anesthesiologists as such as Dr. Covino suggesting dosing through the Tuohy needle as standard procedure for labor epidurals. I would like to express my heartfelt thanks to the authors once again for their very insightful commentary.

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Test-dosing through the Tuohy and the standard of care: the devil is in the details

It was with some interest that I noted the series of letters in the Journal regarding the “role for test-dosing through the Tuohy needle?” since I am the “well-known anesthesiologist at a major teaching institution” who testified for the plaintiff in the case in Virginia alluded to by Dr. Balestrieri. While I do believe that in general it is not great practice to inject local anesthetic via the Tuohy needle, in most cases the injection of “test-dose” amounts of drug is of no great consequence, and may indeed speed analgesia, although even Dr. Balestrieri does not appear to think this should be routine, but rather done only when the catheter fails to thread. I would suggest that injection of saline, rather than local anesthetic, is a more appropriate maneuver.

In the case in which I testified, however, the specific details were important. The patient was an achondroplastic dwarf, less than 4 feet (1.22 m) tall, presenting for cesarean section, in what appeared to be early labor. There was no obstetrician in the hospital. An attempt to place the epidural catheter was being made in a labor room, i.e., not in the operating room. There is controversy about epidural dosing in achondroplastic dwarfs, but multiple case reports suggest higher levels than would be expected in patients of normal height. Certainly, the standard of care in these cases requires extra caution in dosing. I testified that I believed it was a breach of the standard of care to inject...
Other opinions

Is there a role for test-dosing through the Tuohy needle?

There is no literature on the use of the Tuohy needle for epidural test-dosing. However, we have found that at our institution the administration of 2-3 mL of either 1.5% or 2% lidocaine with epinephrine through the Tuohy needle in cases of difficult epidural catheter placement has certain distinct advantages. Because of these advantages a significant number of our attendings routinely use such dosing in cases where it is difficult to advance the epidural catheter following loss of resistance to saline. We have used this technique in over 100 cases during the past three years with some success and without any complications.

The advantages of the technique include the ability to test placement of the Tuohy needle itself before testing the epidural catheter, expansion of the epidural space with 3 mL of test solution which may make advancement of the epidural catheter either possible or less difficult, and earlier onset of pain relief. We have not

IJOA 2007
Other opinions

Is there a role for test dosing through the Tuohy needle?

However, we would suggest that rather than using 2-3 mL of 1.5-2% lidocaine, 10 mL of 0.1% bupivacaine with fentanyl 12 μg/mL is more suitable, a dose already used by 37% of UK units to test epidural catheter placement.\(^2\) Drug administration through the Tuohy needle is not indeed a test dose as all subsequent medication is given via the catheter. It is, however, a method of achieving early onset of pain relief whilst making catheter insertion less difficult.\(^3\)

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dose, as a result of pressure of work. Giving the low-concentration anesthetic bolus through the needle not only tests needle placement but also significantly accelerates the onset of pain relief. I would guess that, even with 3 mL of lidocaine, the author sees significant shortening in the time necessary to achieve patient comfort, although complete relief is probably dependent upon the location of the needle relative to the T10-L1 nerve roots.

I have practiced in three academic institutions as well as a multitude of private practice situations. I have observed that a bolus dose through the needle is a typical practice in a community hospital setting whereas it is considered malpractice by many academicians. I would strongly encourage the academic community to rethink this historical practice and learn from Balestreri’s advocacy of this technique.

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Committing it...
November 1993, Allen Pavilion of CUMC

- 28 year old G2P1, 28 wks gestation, severe PEC, for C/S
  - BP 230/120, 3+ edema (inc. facial)
  - platelets 265K, PT/PTT nl, fibrinogen 550 (TT 30/29)
- Epidural attempted
  - L3-4, lateral---bloody tap (easy)
  - L2-3, lateral---bloody tap (easy)
  - L4-5, sitting---unable to enter x 3
- Arterial line, SNP, esmolol, GA
  - uneventful
November 1993, Allen Pavilion-II

- **Postop 40 minutes**
  - c/o back pain
  - lifts legs (says they feel heavy)

- **Postop 8 hours**
  - ? weakness, L > R

- **Postop 10 hours**
  - Neuro consult--MRI ordered—low suspicion
RMS malpractice-III

- Postop 17 hours
  - MRI--anterior hematoma @ T10-L1
  - Mild-moderate spinal stenosis

- Postop 19 hours--Laminectomy
  - Fair-good immediate recovery

- ?residua----depends if you ask her lawyer or her neurologist

- Legal opinion: defensible, but settled before trial (Bronx)
  - ~ 5 years after event

- ~ 700K from me, 750K from NYPH, 750K from OB
RMS malpractice-IV—WHY SETTLE?

- **Practical**
  - Bronx—it is GOOD to be a plaintiff in the Bronx
  - MLMIC sends letter suggesting my personal assets could be in play, suggests settling
  - EVERYONE (more or less) will be in the National Practitioner Databank

- **Medical/Factual**
  - No specific orders written for AICU neuro check
  - Transfer to 168th St for MRI requested @ 9-10AM, did not happen until 5PM
  - Maybe shouldn’t have tried the second time???