MLMIC®
Medical Liability Mutual Insurance Company

CASE REVIEW

A Review of Case Studies for MLMIC-Insured Physicians & Facilities

November 2017

CASE STUDY #1

Systemic Failures and Poor Care Lead to Death in the PACU

Kerry Kraszewski
Claims Examiner
Medical Liability Mutual Insurance Company

A 43-year-old gravida 3, para 2 female presented for a repeat cesarean section at term to the labor and delivery unit at a women's health center that was part of the campus of a general hospital. The patient's pre-natal care was uncomplicated. However, she had a history of obesity, a previous myomectomy, and a previous cesarean section performed outside the United States.

The patient met the MLMIC-insured obstetrician for the first time when she arrived for her surgery. He reviewed her preoperative blood work, discussed the planned surgery with the patient, and obtained her informed consent.

A female infant with Apgars of 9 and 9 and a birth weight of 9 lb., 4 oz. was delivered. Surgical findings included extensive adhesions from the anterior abdominal wall to the uterus that advanced to the bladder. The placenta and other structures were normal. The patient tolerated the procedure well. She was transferred to the PACU and ultimately to the floor.

The next morning, the patient was seen by a resident and a different obstetrician who was covering the obstetrical service that day. She complained of severe abdominal pain and distention which, at times, failed to respond to analgesics. By the early afternoon, she was tachycardic with a pulse of 138. She continued to receive Dilaudid for pain.

Two days after her delivery, the insured obstetrician came in to see her. He discharged the patient at her request, despite persistent tachycardia and continued pronounced abdominal distention, but without performing an examination. She denied any other GI complaints.

The following morning, the patient returned to the facility by ambulance complaining of severe abdominal pain. She was re-admitted with a diagnosis of postoperative ileus and possible small bowel obstruction. The physician who saw the patient ordered suppositories and an enema, which were administered but did not relieve her pain.

After admission, the patient was up and walking in the hallway. However, several hours later, when the patient was finally examined by the obstetrician, she was febrile and slightly short of breath. The physician attributed this solely to her abdominal discomfort. His clinical impression was an ileus versus a bowel obstruction. He ordered abdominal x-rays, a CBC, blood cultures, and IV antibiotics.

At 5:30 p.m., the patient appeared to be fairly comfortable. Her temperature was 99.9, but her pulse rate was 137. Her white blood count was also elevated. Her hematocrit and hemoglobin were normal. Abdominal films revealed air and fluid, confirming the possibility of a bowel obstruction. The obstetrician contacted the general surgeon on call at the main hospital campus requesting a consultation. The surgeon reviewed the films and recommended that the patient be transferred to the main campus of the hospital for a CT scan. After he reviewed those results, he advised he would then perform a formal consultation.

continued on page 2

November 2017

Case Review **is published under the auspices of MLMIC's Patient Safety & Education Committee, Donald J. Pinals, MD, Chairperson.**

Editorial Staff

John Scott, Editor
Mark Collins
William F. Fellner
Gerald J. Glum
Kathleen L. Harth
Timothy Howell
Edward Krause
Linda Pon
Donnaline Richman, Esq.
Daniela Stallone

MLMIC Offices

2 Park Avenue
New York, NY 10016
(800) 275-6564

2 Clinton Square
Syracuse, NY 13202
(800) 356-4056

90 Merrick Avenue
East Meadow, NY 11554
(877) 777-3560

8 British American Boulevard
Latham, NY 12110
(800) 635-0666

300 International Drive, Suite 100
Williamsville, NY 14221
(716) 648-5923

Fager Amsler Keller & Shoppmann, LLP attorneys are available during normal business hours to assist policyholders with a wide range of legal services, including, but not limited to, advisory opinions concerning liability issues, liability litigation activities, lecture programs, consulting services, and legal audits and assessments.

Case #1 *continued*

While the patient awaited transportation by ambulance to the main campus, she developed increased respiratory distress. Because she was unstable medically, she was evaluated by both her obstetrician and an anesthesiologist, who ordered IV fluids. When the ambulance crew arrived, they performed an EKG at the direction of the emergency room physician at the main hospital campus.

The patient was then transported to the hospital by only the emergency medical services staff. A CT scan was performed at 7:54 p.m. and interpreted at 8:18 p.m. The radiologist's impression was a mottled collection of fluid and air, which was most pronounced between the uterus and the anterior abdominal wall. This raised the likelihood of infection, a hematoma, peritonitis, and a bowel perforation. She had free fluid scattered within her abdomen and peritoneal cavity.

The surgeon then contacted the obstetrician and informed him that he declined to operate on the patient. In his opinion, the obstetrician should perform the surgery because the hematoma resulted from the cesarean section. Unfortunately, the obstetrician was the only physician present at the women's health campus and he could not leave there until relieved. Therefore, he made a series of urgent telephone calls to both the obstetrician on call at the hospital campus, as well as to the patient's prenatal care provider. Both physicians refused to accept the patient. He then called a tertiary care center to request a transfer there. This also was refused. Finally, the chairperson of the OB/GYN Department of the hospital agreed to examine and treat the patient. However, she arrived at the hospital forty minutes after being called. By that time, the insured obstetrician had obtained coverage and arrived at the hospital.

Despite the fact that the hospital had been notified earlier that the patient was being transferred for emergency surgery, the patient was still in the emergency room. She had not had a medical screening examination by the emergency department physician and was sweating profusely and experiencing continued respiratory distress. When she was finally taken to the operating room, surprisingly, no operating room team had been assembled. Nor was the room prepared for surgery. Further, the patient had not been prepared for surgery by the staff, thus creating further delays. Finally, the obstetrician performed an emergency exploratory laparotomy and evacuation of a hematoma. A portion of the ileum was resected and an ileostomy created. His operative report described a small segment of ischemic bowel, densely adherent to the lower right quadrant of the abdomen. He concluded this was probably the area of perforation.

After the surgery was completed, the patient was moved to the PACU where she suddenly experienced a full cardiorespiratory arrest. Despite intensive resuscitative efforts, she expired. The patient was survived by her husband, a 5-year-old son, and the newborn daughter. An autopsy determined the cause of death to be peritonitis and ischemia of the small bowel. Adhesions, bilateral pleural effusions, bilateral atelectasis, hypertrophy of the uterus, and hepatosplenomegaly were also noted.

This case was reviewed by MLMIC experts in obstetrics and gynecology, general surgery, and hospital administration. The obstetrical expert opined that this patient's death was preventable and that the insured could not be defended. This opinion was based in large part on the extensive adhesions encountered during the cesarean section, as well as the patient's obesity and

prior surgical history. The obstetrical expert was also very critical of the hospitalist's orders for an enema in the absence of a definitive diagnosis. This likely worsened the patient's peritonitis. Further, this expert stated definitively that the insured should have "run the bowel" to check for perforations.

The MLMIC expert in general surgery concurred that the failure to "run the bowel" was a significant deviation from the standard of care. He also opined that discharging this patient from the hospital in an unstable condition (continued tachycardia and distended abdomen) was a further serious deviation.

All three expert reviewers were extremely critical of the hospital system. They found the hospital's on call system not only markedly deficient but violative of state and federal law. The expert hospital administrator opined that deficiencies in the hospital system included a lack of planning for proper emergency patient care upon receipt by the hospital campus and the lack of proper emergency policies, procedures and processes for the entire system, including the women's health center. This expert also opined that the hospital's chairperson of obstetrics should have directed the hospital's on call obstetrician to accept this patient and respond promptly. Finally, the hospital's failure to have the operating room properly staffed, equipped and ready for the emergency surgery, despite being given advance notice of this emergency admission, led to further delay. Thus, the hospital clearly failed to comply with state and federal regulations governing the proper care of an emergency patient.

This case was also reviewed by an outside obstetrical expert. He was very critical of the insured obstetrician's decision to discharge the patient on the second post-operative day with continued complaints of pain and without an examination. Additionally, this expert was highly critical of the failure of this hospital system to have appropriate physicians immediately available to respond to a life-threatening situation.

Two months after the patient's death, the decedent's husband commenced a lawsuit against both the MLMIC-insured obstetrician who delivered the patient and the hospital. Because MLMIC was unable to obtain an expert to defend the insured, the case was settled for $2.6 million. The majority of the settlement was paid by the MLMIC defendant, with some contribution by the non-MLMIC-insured hospital system.

CASE #1 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

Donnaline Richman, Esq.
Fager Amsler Keller & Schoppmann LLP
Counsel to Medical Liability Mutual Insurance Company

There were numerous legal and risk management problems with the care provided to this patient. The most obvious issue was inappropriate patient selection for delivery at the women's health center, which was a separate unit on the main campus of the hospital. When a patient has complex risk factors for delivery, necessary staff, specialists and consultants must be immediately available in the event of a problem. Additionally, the failure of the delivering obstetrician to carefully examine ("run") the bowel, despite the patient's past surgical history and the extensive adhesions observed during surgery, precluded his seeing the perforation. This was a serious deviation from the standard of care that could easily be proved by an expert witness. Finally, discharging an unstable patient with abdominal and respiratory symptoms, two days after surgery and without performing a physical examination, was a serious deviation from the standard of care. If the obstetrician had performed a careful physical examination, he might have recognized that the patient's condition was unstable and that retaining her at the facility would have avoided an emergency readmission.

The refusal by several on call physicians to accept this patient at the main hospital campus was also a major factor in her demise. The definitive treatment she required was seriously delayed, causing further destabilization of her emergency medical condition. Physicians who refuse to respond when called run the risk of violating the hospital's medical staff by-laws governing on call responsibilities, therefore subjecting themselves to possible medical staff disciplinary action.

The refusal by several on call physicians to accept this patient at the main hospital campus was also a major factor in her demise.

The health center did not send appropriate medical/nursing staff with this patient during her transport between campuses. Further, the patient required emergent care upon her arrival by a member of the main hospital's medical staff, as required by law.[1] The regulations provide that every patient of the hospital, whether an inpatient, emergency service patient, or an outpatient, shall be provided care that meets generally acceptable standards of professional practice. In this case, not only did the patient wait in the emergency department for care, but also the operating room was not prepared for her emergency surgery.[2] As a result, this patient's rights under New York State law were violated.[3]

The physician who finally agreed to accept care of the patient at the hospital campus failed to arrive at the hospital for more than 40 minutes after being called. New York State hospital regulations provide that a physician be available in person within 30 minutes.[4] This further delayed the necessary treatment, since surgery could not be immediately commenced when the patient was finally taken to the operating suite.[5]

Overall, the hospital's response to this emergency was extremely poor. Clearly the facility lacked well-defined policies and procedures governing emergency transfers from its other campus.

In summary, this case was indefensible from the perspective of the actions and decisions of the delivering obstetrician, and the lack of preparedness of the operating team. All of these failures clearly justified the decision to settle this lawsuit.

1. 10 NYCRR § 405.2(f)(2) and 405.2(f)(1)
2. 10 NYCRR § 405.12(a)1(i)
3. 10 NYCRR § 405.7(b)(4)
4. 10 NYCRR § 405.2(f)(4)
5. 10 NYCRR § 405.19(a)(2)(i) and (ii)

CASE STUDY #2

Inadequate Staffing Leads to Post-Treatment Disaster

Gerald J. Glum
Vice President, Claims
Medical Liability Mutual Insurance Company

A 58-year-old male patient with unrelenting pain in the left arm following left rotator cuff repair surgery was seen by a MLMIC-insured anesthesiologist for pain management. This patient had a chronic regional nerve pain syndrome allegedly due to the infiltration of an IV during surgery performed six weeks earlier. Treatment with Neurontin 300 mg BID was unsuccessful. The patient rated the pain in his entire left upper extremity as 10/10. He had pain with even the slightest shoulder movement. His left hand and wrist were edematous and very warm. Following his examination, the insured anesthesiologist recommended a series of stellate ganglion blocks, in coordination with aggressive physical and occupational therapy.

The patient's past medical history revealed that he underwent cardiac testing prior to the shoulder surgery because of complaints of intermittent chest pain and shortness of breath on exertion. An EKG, exercise stress testing, and chemical stress testing ruled out ischemia and thus the patient was cleared for the shoulder surgery.

The patient initially underwent a series of left stellate ganglion blocks at the C-6 level on the left side for eight weeks. He had no complications and seemed to benefit from these injections. The procedures were performed on an outpatient basis in the pain management suite of the local hospital.

The patient arrived for his ninth injection at 4:40 p.m. He was assessed by the admitting nurse. His vital signs were: BP 128/74, pulse 76, respirations 16 and oxygen saturation 98%. The patient's procedure began at 5:07 p.m. The insured anesthesiologist administered IV propofol 100 mg for sedation. He gave additional doses of propofol 50 mg at 5:12 p.m. and 5:15 p.m. The patient's vital signs at that time were: BP 109/70, pulse 73, and 96% oxygen saturation.

Lidocaine was injected by the anesthesiologist at the C-6 level and an anesthetic catheter was inserted under fluoroscopic guidance. To confirm proper placement, 2 cc of contrast was injected through the catheter. Aspiration was then performed to confirm that the catheter was not placed intravascularly. He then administered 10 cc of bupivacaine with 0.5% lidocaine without complication. At 5:17 p.m., the patient's vital signs were: BP 109/70, respirations 18 and oxygen saturation 95%. The procedure was completed at 5:19 p.m.

At 5:30 p.m., the patient was taken to the recovery room. His vital signs were: BP 111/74, pulse 71, respirations 16, and oxygen saturation 97%. Because patients undergoing this procedure do not usually require continuous monitoring, they are typically evaluated by registered nurses every five to ten minutes. At 5:45 p.m., the nurse documented that the patient was drowsy, but responsive, and could swallow without difficulty. His vital signs were: BP 107/68, respirations 16, and oxygen saturation 97%. The patient's 13-year-old son was present with him in the recovery room.

After 5:00 p.m., there were only two nurses on duty in the pain management suite. The receptionist and admitting nurse for this area regularly left at 5:00 p.m. The nurse monitoring this patient left him to assist the physician with his next case. The remaining nurse was responsible not only for monitoring the patient in the recovery room, but also for admitting other patients scheduled after 5:00 p.m., as well as answering the telephone. While this nurse was in another room preparing the next patient for a procedure, she heard a commotion at the front desk. The patient's son was requesting immediate assistance for his father because a monitor alarm was ringing.

When the nurse reached the recovery room, the patient was apneic, cool, dusky and pulseless. At 5:55 p.m., she called a code blue and summoned the anesthesiologist, who had not yet begun his next procedure. He and numerous hospital staff responded promptly to the code. Resuscitation efforts included CPR, intubation, the administration of epinephrine and atropine, and

continued on page 6

defibrillation. Finally, at 6:14 p.m., the patient's heartrate was reestablished. He was in asystole for at least 19 minutes and suffered an anoxic brain injury, secondary to his cardiac arrest. The patient's condition did not improve in the hospital so he was transferred to a nursing home. He remains there today in a vegetative state.

A lawsuit was commenced on behalf of the patient. The case was reviewed for Medical Liability Mutual Insurance Company by experts in anesthesiology. They found that the decision to proceed with a series of stellate ganglion blocks was appropriate. However, one expert expressed serious concern that the patient was given 200 mg of propofol over an eight-minute time frame. Giving such a high dosage clearly requires close monitoring of the patient in the recovery room. Further, the expert opined that more time should have been scheduled between cases to permit the staff to closely monitor patients in the recovery room.

The expert reviewers were unanimously critical of the inadequate staffing of this hospital unit, which allowed this catastrophic complication to occur. Staffing of this unit after 5:00 p.m. had been inadequate for an extended time period. However, multiple requests to hospital administration to increase the nursing staff after 5:00 p.m. had been denied. Thus, the anesthesiologist would have had a difficult time convincing a jury that he was the only physician at the facility who was unaware of the inadequate staffing. Yet, despite this knowledge, he continued to perform procedures after 5:00 p.m. Following this event, the hospital promptly increased the number of registered nurses working in the unit after 5:00 p.m.

Because of these issues, the experts recommended settlement of the lawsuit. The hospital settled the lawsuit for $1.5 million. However, the anesthesiologist did not have excess insurance. Thus, defending him in court without the co-defendant was problematic. Therefore, he consented to settle and the case was resolved for $500,000 rather than continuing to defend the lawsuit in court.

CASE #2 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

Donnaline Richman, Esq.
Fager Amsler Keller & Schoppmann, LLP
Counsel to Medical Liability Mutual Insurance Company

This case points out clearly how important adequate hospital staffing is to physicians who practice at these facilities after hours.

As the case study noted, the credibility of that physician was vital to his being able to defend the lawsuit. When a physician's credibility is undermined at trial, a jury may punish that physician by rendering a verdict for the plaintiff, despite the hospital's liability. This physician was advised to settle the lawsuit once the facility settled with the plaintiff, because he had continued to perform his procedures after hours, despite being aware of chronically inadequate staffing. If he had denied being aware of, or having control over, this situation, his credibility would have been at issue. While it may be difficult to be persistent when dealing with hospital administration about a dangerous lack of professional staff for after hours procedures, clearly the risk to both the patient and physician is great for failing to decline to continue working under unsafe patient conditions.

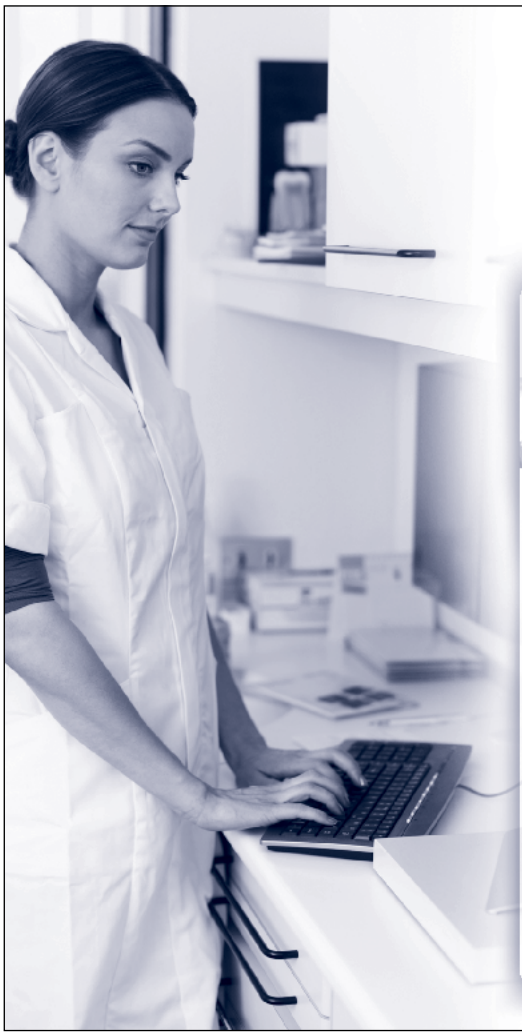
The physician's potential liability also revolved around the large dose of propofol he delivered over a short time period. Because close monitoring of a patient who receives such a large dose is indicated, the physician's failure to schedule his later procedures at greater intervals in order to confirm the patient has suffered no sequalae in the recovery room could be argued to be a deviation from the standard of care. This became a more crucial factor since the length of time between this catastrophic event and the resuscitative efforts was prolonged by the lack of close monitoring. The physician's liability would have been based on his not being immediately available to this patient after giving such a large dose of medication.

Finally, the physician's failure to maintain excess insurance coverage was an additional basis for prompt settlement of the case. Excess insurance might have permitted him to continue to defend this case despite the deficits by arguing that he was not legally responsible for hospital staffing, nor for the failure of the existing nursing staff to closely monitor the patient. However, once the hospital settled with the plaintiff before trial, the monetary risk to the physician was too substantial to proceed.

Medical Liability Mutual Insurance Company
2 Park Avenue
New York, NY 10016

PRESORT STANDARD
U.S. POSTAGE
PAID
PERMIT #1174
NEW YORK, NY

MLMIC.com



The MLMIC.com Blog

For the latest company news and insights into hot topics in the industry affecting physicians today, sign up for the MLMIC blog.

See what the blog can do for you. Visit **mlmic.com/blog**