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

CASE STUDY #1
Negligent Spinal Surgery Leads to Paralysis

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A 250-pound 44-year-old construction worker came to see the defendant, a board certified orthopedist, on August 31, 2005, with a history of twisting his neck while on a ladder at work five days earlier. An MRI revealed a bulging disc at C6-7 impinging on the right neural foramen. The plaintiff was started on physical therapy, steroid injections, and pain medications, which initially gave him some relief. However, in early February 2006, he returned to the defendant with complaints of an acute recurrence, limited range of motion of his neck, increased pain, and diminished right triceps strength. Further radiologic studies revealed stenosis of the neural foramen on the right and a suspicious small right lateral disc herniation. Compared with the prior MRI, the herniation was clearly larger. Surgical intervention was recommended.

On April 10, 2006, the defendant and a co-defendant, a board certified neurosurgeon, performed the surgery at 8:05 a.m. The co-defendant board certified anesthesiologist performed the intubation and extubation, and was present for the patient’s emergence from anesthesia. An intraoperative x-ray located the offending disc. Due to the patient’s short, large neck, an incision was made along the left side of the neck, contiguous to the sternocleidomastoid muscle. Consecutive x-rays were taken to confirm the appropriate locus. A free fragmented disc was removed at the C6-7 level on the right. Cadaver bone was placed in the disc space and secured by two screws in the vertebral body on both sides. Bipolar electric cautery was employed to stop bleeding. Gelfoam soaked in thrombin was placed against any bleeding spots. A drain was placed over the palate to prevent the accumulation of blood behind the esophagus. The wound was irrigated before closure to prevent infection. Hemostasis was achieved, and there was a three layer closure. The procedure lasted a total of 89 minutes and was considered to be uneventful.

At 10:00 a.m., the defendant orthopedic surgeon and the CRNA accompanied the patient to the PACU. Upon arrival, the defendant performed a neurologic examination. The patient was awake and able to move all of his extremities. This examination was documented in the record. The PACU’s protocols and preprinted orders required neurovascular checks every 30 minutes. The defendant surgeon specifically crossed out the preprinted postoperative order for the use of PCA for this patient. The defendant then wrote post-operative orders for Percocet every four hours prn and morphine every two hours prn following discharge from the PACU. However, he did not order pain medication for the PACU. This was considered the responsibility of the anesthesia provider. The co-defendant CRNA wrote orders for fentanyl and Demerol while the patient was in the PACU. These were countersigned by the defendant anesthesiologist.

Within 18 minutes of the patient’s arrival in the PACU, the co-defendant RN documented that the patient was complaining of severe pain. The co-defendant anesthesiologist was called by the RN due to the patient’s continuing complaints of severe pain. He came to see the patient at 11:15 a.m. and ordered PCA. He ignored the fact the defendant surgeon had deleted that particular standing order. Nor did he write a progress note describing why he was called or the care he rendered. The PCA was started at 12:30 p.m. The pain medication prescribed was in addition to the standing orders previously written by the CRNA. The RN documented that she gave all

continued on page 2
Case #1 continued

medications “as ordered” by the defendant anesthesiologist.

Throughout the patient’s stay in the PACU, the RN documented completion of neurovascular checks at 10:00 a.m., 10:30 a.m., 11:30 a.m., 12:30 p.m., and 1:30 p.m. According to this documentation, the patient was able to move his arms and legs, obey verbal commands, and was alert and oriented at all times. His motor function was rated 5/5. Yet, the medical record indicated that the patient was sleeping at 12:50 p.m. and was in a sedated state at 1:15 p.m. and 1:30 p.m. No neurovascular evaluations were documented after 1:30 p.m. It was not until 2:15 p.m. that the RN first observed that the patient could not move his legs.

At 2:30 p.m., the defendant surgeon was finally informed that the patient could not move his extremities after awakening. He promptly examined the patient, confirmed that the patient’s arms were weak and that he could not move his legs, and ordered a Foley catheter and an injection of a steroid. He then personally took the patient for an emergent MRI which demonstrated bleeding from C4 to T2. The hardware was in good position.

The patient was returned to surgery at 4:07 p.m. in an attempt to decompress the spinal cord. The defendant surgeon employed a posterior approach which limited visualization of the space. He split muscle off the bone, performed a laminectomy from C3 to T4, and removed the ligament covering the spinous processes. The size of the hematoma was identified as the cause of the bleeding. The defendant surgeon later received a telephone call from this neurosurgeon. He advised that there had been a spinal fluid leak that required repair. He had performed a posterior fusion and discovered a bony spike, which he believed caused the spinal fluid leak.

Two years after the initial surgery was performed, the patient commenced a malpractice suit against the hospital, the PACU RN, the orthopedic surgeon, his PC, the initial neurosurgeon, his PC, the anesthesiologist and the CRNA. The allegations included: failure to properly evaluate the plaintiff’s pre-operative condition; negligent performance of all three surgeries; failure to timely and properly assess the plaintiff’s medical/neurological condition
post-operatively; failure to appreciate the significance of his continuous complaints of severe pain in the PACU; failure to perform neurovascular checks and other relevant evaluations in the PACU required by hospital protocols; and overmedication of post-operative pain.

The plaintiff’s injuries were severe. In addition to being paralyzed from the waist down, he suffered from osteoporosis; low back pain; recurrent bladder infections; sexual dysfunction; neurogenic bowel; pitting edema distally; hypertonicity of the muscles; clonus of both ankles; decreased libido; irrigation and debridement of gluteal abscesses; perianal abscesses; penile sores; and increased urinary leakage and wetting. All injuries were alleged to be permanent in nature.

There were 18 months of depositions. At his deposition, the plaintiff was a very sympathetic witness. He had good muscle tone in both arms and had control of his upper body including his head, neck, torso, and arms. He stated that he usually spent the day strapped in a wheelchair. He was intelligent, well-spoken, and even managed to inject some humor into his very difficult situation.

The PACU RN testified that the anesthesia physicians were in charge of the recovery room. She testified that, in her experience, a cervical discectomy is painful and anxiety producing. However, her testimony was filled with major inconsistencies. She stated that the orders written by the defendant orthopedic surgeon applied to both the PACU and the floor, yet she previously testified that only anesthesia providers issue PACU orders. She admitted that she was aware that the defendant surgeon had crossed out the standing order for PCA and confirmed that the CRNA wrote orders for fentanyl and Demerol. However, she claimed that the anesthesiologist had given her at least five different medication orders while she was caring for the plaintiff. She insisted that four of these five orders were verbal. Yet, she failed to document all of these orders. She also failed to have these orders cosigned. She could not recall whether the anesthesiologist was actually present in the PACU at 11:15 a.m., as she had documented.

She testified that she gave the plaintiff 50 mcg of fentanyl at 10:15 a.m. as ordered. She again gave him another 50 mcg of fentanyl at 10:25 a.m. because he was banging on the side rails and complaining of severe pain at the operative site. She stated she called the anesthesiologist at 10:25 a.m. and that he gave her a verbal order for 8 mg of morphine IV. She testified she did not document this conversation because the plaintiff required a great deal of care, was in severe pain, and constantly required medication. He appeared both uncooperative and in pain, and she testified that she was unable to “get a handle on him.” At 10:45 a.m., she again called the co-defendant anesthesiologist because the plaintiff continued to have severe pain. She testified that the anesthesiologist ordered two doses of 2.5 mg of Valium IV to be given at intervals of 10 minutes. However, she also failed to document this order. She did record giving the plaintiff Valium at 10:45 a.m. and 11:00 a.m. Because the patient seemed to be “gobbling up the narcotics without relief,” she again called the co-defendant anesthesiologist at 11:15 a.m. She asked him to come to the PACU. She suspected the patient had a drinking

continued on page 4
or drug problem because all of the pain medications were ineffective. The co-defendant anesthesiologist did come to the PACU and examined the plaintiff. He determined that the plaintiff could move all of his extremities. He gave a verbal order for another dose of 4 mg of morphine with 12.5 mg of Phenergan to relax the patient, since the Valium failed to work. Again, the medications were documented when given, but the verbal orders were not. Sometime between 11:30 a.m. and 12:30 p.m., the RN again contacted the co-defendant anesthesiologist. None of the newly ordered pain medications had worked. She testified he then ordered Dilaudid via PCA. The first 1 mg dose of Dilaudid was administered at 11:30 a.m.; the second, at 11:40 a.m.; the third, at 11:50 a.m.; and the fourth, at noon. The record does not indicate when the last dose was administered. The plaintiff finally fell asleep around 12:30 p.m.

The defendant RN admitted that she failed to contact the defendant surgeon. Further, she finally admitted that she failed to perform the required neurovascular checks on the patient until just prior to his discharge from the PACU because she was busy with other patients.

The defendant orthopedic surgeon was deposed next. He made a good witness. He recounted that he treated the plaintiff conservatively until his condition deteriorated and necessitated surgery. He testified to an in-depth informed consent discussion covering the type of surgery, the associated risks, the possibility of infection, and the possibility of paralysis in 1 in 10,000 cases. He also discussed that non-union can occur in smokers. The plaintiff was medically cleared for surgery. The defendant surgeon testified about the surgery, his post-operative neurovascular examination of the plaintiff in the PACU, and his post-operative orders. He testified that he responded immediately when notified that the plaintiff was unable to move his extremities and quickly performed the second surgery. Further, he sought appropriate consultations leading to the identification of a factor XIII defect.

The co-defendant anesthesiologist was then deposed. He was not a good witness. He and the co-defendant CRNA provided continuous monitoring of the plaintiff during the procedure. At the end of the procedure, the plaintiff was stable, moving all extremities, breathing adequately, and able to be aroused. He confirmed that the CRNA wrote the medication orders for the PACU and that he had co-signed them. He testified he ordered the use of PCA for when the patient was discharged to the floor, but he neither dated nor timed that order. He admitted that although he was aware that the orthopedic surgeon had put a line through the standing PCA medication order, he did not question this. He further acknowledged that he most likely gave verbal orders to the co-defendant RN for morphine sulfate, Valium, and Phenergan, as well as the first dose of Dilaudid. However, he insisted that he did not authorize her to give additional doses of IV Dilaudid. The medication records confirmed three doses of Dilaudid 1 mg were given; one at 11:30 a.m., one at 11:40 a.m., and one at 11:50 a.m. He specifically denied giving the co-defendant RN verbal orders for Dilaudid 1 mg to be given multiple times at 10 minute intervals because this drug is not effective for 30-60 minutes. Therefore, he testified that not only did he not give this order, but he did not recollect any discussions about this drug with the co-defendant RN. Finally, he
testified he would never give any RN an order to administer Dilaudid at his/her own discretion. He opined that giving this much Dilaudid IV over a 30 minute period was excessive. He further testified that he had never ordered such a dosing regimen in his entire career. His testimony was in direct conflict with that of the RN and had clearly deteriorated into a “he said, she said” scenario. Because of the serious lack of documentation by the co-defendant anesthesiologist in the PACU record, it was significantly problematic defending his care.

Multiple experts reviewed this case for MLMIC on behalf of three insured co-defendants: the orthopedic surgeon, the original neurosurgeon, and the anesthesiologist. All experts agreed that this was a difficult case to defend, particularly with such a sympathetic plaintiff. The neurosurgeon’s care was deemed to be the most defensible. He had very limited involvement in the first two surgical procedures. The orthopedic surgeon’s care was initially felt to be defensible because this is a rare complication. However, there were several problems defending him. Within 18 minutes of his arrival in the PACU, the plaintiff required pain medication. The experts felt that this indicated bleeding because blood irritates the spinal cord, causing pain. The orthopedic expert further opined that the likely cause of the bleeding was the epidural veins which course over the dura. Veins possess no muscular wall, bleed immediately when transected, and there are numerous small veins in the spinal canal. However, the expert also was concerned that true hemostasis was not achieved prior to closure. Additionally, the subsequent treating neurosurgeon at the other hospital documented in his operative note that there was a rent in the plaintiff’s dura as a result of a bony spike which was not recognized during the first surgery. Another reviewer criticized the defendant orthopedic surgeon for not sending the aspirated fluid from the third surgical procedure to the laboratory. If he had done so, he would have learned that the fluid was actually from a CSF leak and not a seroma. This made his defense problematic.

Despite the RN’s testimony, the manner in which this surgery is performed is not particularly painful. The experts who reviewed the care of the co-defendant anesthesiologist all believed that the abnormal amount of pain the plaintiff experienced postoperatively, and the excessive amounts of pain medication he required, should have signaled that there was a serious problem. The defendant orthopedic surgeon should have been contacted immediately. Because of this failure, the defendant surgeon was deprived of the opportunity to address the post-operative hematoma earlier. Further, because the hematoma extended from C2 to T5, it likely formed over several hours. Thus, all of the experts concurred that the lion’s share of responsibility for the plaintiff’s injuries rested with the co-defendant anesthesiologist and also with the co-defendant RN.

The plaintiff’s attorney demanded $12 million to settle the case. The assigned judge actively tried to resolve the lawsuit. He requested that the plaintiff’s counsel provide all counsel with a life care plan and an economist’s report. In addition, there were liens of close to $1 million in medical expenses to be paid by any settlement or judgment. After several months of negotiations, the litigation was finally settled for $7.6 million. Of this, $600,000 was paid on behalf of the defendant orthopedist, $750,000 on behalf of the defendant anesthesiologist and the remainder on behalf of the hospital and PACU RN.

A Legal & Risk Management Perspective

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This case, which resulted in a catastrophic outcome, contained very serious legal and risk management deficits.

There was a clear and continuous lack of communication between a variety of providers. The lack of communication between the PACU nurse and the orthopedic surgeon was disastrous for this patient. When a patient reacts in an aberrant manner to a procedure, the PACU nurse must promptly notify the surgeon since he/she has the greatest knowledge and experience with the patient. Further, when a patient experiences pain well beyond what is anticipated from the beginning of his PACU stay, it is clear something unusual and untoward is occurring. This too warrants a prompt personal communication with the surgeon. Moreover, the anesthesiologist also failed to ask the orthopedist why he crossed off the PCA in his post-operative orders, nor did he advise him of his patient’s excessive pain.

There was a serious lack of documentation of and failure to co-sign, verbal orders and other alleged communication between the PACU nurse and the anesthesiologist. The documentation was poor, at best, or absent with respect to medications ordered and given. Further, there was some indication that the nursing documentation about neurovascular checks was inaccurate or even false.

continued on page 6
Additionally, the anesthesiologist failed to document his examination of the patient at 11:30 a.m. This failure to document the patient’s assessment, as well as all of his verbal orders over several hours, led to finger-pointing between him and the co-defendant RN during the depositions. This situation benefits only the plaintiff. Further, the anesthesiologist inappropriately delegated to the CRNA the writing of orders for the PACU which he later co-signed. CRNAs are specifically trained RNs who are authorized by the Department of Health regulations to administer anesthesia which is part of a medical regimen. While a CRNA may suggest medications and related doses to an authorized prescriber for a specific patient, the CRNA does not have the authorization to independently prescribe medications.\(^1\) CRNAs are not licensed by New York State as advanced practitioners, e.g., NPs. As such, it is professional misconduct for a physician to delegate to a CRNA tasks which are outside the scope of practice, e.g., writing postoperative anesthesia orders.\(^2\)

One of the most serious problems in defending this case was the nurse’s failure to complete neurovascular checks in accordance with the PACU protocol. Since the patient was documented to be sleeping after being given so much sedation sometime after noon, it seems unlikely that some or all of these checks were completed. The RN admitted as much during her EBT. Any false entry in the record is not only professional misconduct for both physicians and nurses, but could carry criminal penalties as well.\(^3\) Further, the hospital protocols for patient monitoring are in place to protect patient safety. They were also evidence in this case of the standard of care for the PACU. Therefore, any deviation in following such protocols can be readily used by a plaintiff as evidence of a clear deviation from the required standard of care.

Although much of the care by the orthopedic surgeon was felt to be defensible, his defense was difficult because he failed to send fluid he aspirated to the laboratory for analysis. This was a crucial error, since he incorrectly identified the nature and source of the fluid. The laboratory would likely have advised him that this was cerebral spinal fluid and not from a seroma.

Finally, in such a catastrophic case, the jury might well wonder why a physician would leave town with such a seriously ill and unstable patient in the hospital. As a result, they may financially penalize the physician for “abandoning” his patient, despite the physician having arranged for competent coverage for the patient’s care. The covering physicians and the primary attending must communicate at changeover so that the covering physician is fully knowledgeable of what has transpired before assuming care of a very complicated patient. The surgeon also should have communicated with the patient and his family that he was leaving and, if possible, introduce the covering physician before he left.

The impact of the type of injuries suffered by this plaintiff upon a jury is significant. If this case had gone to trial, this particular plaintiff would likely have been a very sympathetic and excellent witness. That is why, defense problems aside, strenuous efforts had to be made to resolve this case. The resolution involved the use of a structured settlement, which involves the purchase of annuities to periodically pay the damages agreed upon over time.

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1. Opinion Letter from Barbara Zittel, RN, PhD, Executive Secretary of the New York State Board of Nursing, to Fager & Amsler, LLP, 9/9/04.
2. NYS Education Law § 6530(11).
3. NY Penal Law §§ 175.05, 175.10.
A married 58-year-old retired computer manager was seen by a urologist on 8/8/04. He gave a medical history of Lasik surgery and back problems at L4-L5. He had an elevated PSA level of 4.9 after testing three weeks earlier by his primary care physician. Following a trial of Cipro, his repeat PSA was 4.1. On 8/13/04, a uroflow evaluation was almost normal. The urologist ordered a repeat PSA test and a sonogram. On 8/17/04, his PSA level had increased to 4.18. The sonogram revealed a questionable prostate nodule (small hypoechoic area). On 8/19/04, the prostate gland was approximately 30 grams with a questionable irregularity on the right side. On 8/23/04, a biopsy of the prostate gland was positive for cancer, with a Gleason score of 3 plus 3, involving 3 of 6 cores. The patient underwent a total body CT scan on 9/8/04. This test was interpreted as showing a normal sized prostate gland with no evidence of periprostatic spread of the cancer.

On 9/9/04, the physician discussed these results with the patient and referred him for follow-up to the defendant urologist, who worked in this same practice. The defendant urologist first saw the patient on 9/13/04. He discussed the patient’s diagnosis and treatment options. The patient chose to undergo a robotically-assisted laparoscopic prostatectomy (RALP). Given the patient’s Gleason score and PSA level, the defendant urologist also discussed with the patient the risks and benefits of radiation and surgery, including the risks of impotence, incontinence, and the possible need for further surgery and/or therapy.

The patient received medical clearance and, on 10/5/04, he underwent a RALP at the co-defendant hospital. The operative report described a small prostate, with a difficult dissection due to the patient’s narrow pelvis. In addition, there was a small amount of fat around the prostate. The bladder neck was identified and transected. Indigo carmine was administered and blue urine efflux was noted coming from the bladder. The seminal vessels were dissected and the vasa transected. The prostate was mobilized, a dorsal venous stitch was used, and bipolar cautery transected the remainder of the dorsal vein. The urethra was transected using a hook cautery. The Foley catheter was removed. The prostate was disconnected from its attachments. Hemostasis was obtained with bipolar cautery.

The pathology report indicated the specimen was 4.1 cm x 2.6 cm x 0.6 cm and weighed 5.7 grams. After immunohistochemical studies were performed to rule out prostatic adenocarcinoma, the
pathologic diagnosis was “benign prostate tissue.” An addendum made to the original pathology report indicated that the specimen was then sent for review by an outside anatomic pathologist, who concurred with the original diagnosis. This second pathologist issued a subsequent report dated 11/3/04 and “noted multiple areas where the benign cells reached the ink.” Because of this, and the light weight of the prostate gland, he reported that “it is likely that the entire prostate gland has not been removed.” He further reported that robotic prostatectomies “can result in the same positive margin rate as an open prostatectomy and are associated with a long learning curve.”

On the fifth post-operative day, the patient complained that he was passing urine around the Foley catheter. Two days later, the Foley catheter was removed and the incision had healed. The patient was able to maintain erections. He was advised to have a PSA test in one month. He was to be seen again upon his return from vacation. Nine days later, the patient complained of mild dysuria. A urinalysis revealed traces of red and white blood cells. Levaquin and Urelle were prescribed.

On 12/29/04, the patient was again seen by the treating urologist. He was able to have erections using low dose Viagra and was no longer incontinent. The urologist advised the patient to have a repeat PSA level performed. If the PSA level was detectable, the patient was to be referred for external beam radiation therapy. The patient did go for a PSA test and his PSA level was 4.87. This further indicated that the entire prostate gland had not been removed. On 1/18/05, the patient had another MRI. The prostate gland measured 3.8 cm x 2.1 cm x 2.7 cm for a calculated volume of 10.8 cc. The radiologist initially interpreted that this finding was due to a defect from a central transurethral resection of the prostate (TURP). However, this patient never had a TURP procedure. When advised of this, the radiologist then attributed his finding to scar tissue from the RALP. The defendant urologist referred the patient to a radiation oncologist to seek further treatment options. Instead, the patient sought treatment by urologists at another facility.

In September 2006, the plaintiff commenced a lawsuit against the urologist who performed the robotic surgery, his professional corporation, the hospital, the pathologist, and two physician assistants employed by the hospital.

On 2/25/05, his new urologist recommended further surgery to cure the cancer. The risks and complications of this surgery were discussed with him and on 3/21/05 the patient underwent a radical retropubic prostatectomy. However, because the prostate gland was not palpable, the bladder was overlying the prostate gland, and there were marked adhesions, the procedure was aborted. The patient was instead advised that he should undergo radiation therapy. On 3/28/05, his new urologist documented that the patient was able to maintain erections and was not incontinent. He was then seen by a radiation oncologist, who documented that his erectile function was 3/3 with no urinary symptoms. It was felt that the patient was not a good candidate for seed implantation, due to the large defect in his urethra. The patient then saw another radiation oncologist, who did recommend primary brachytherapy. An ultrasound evaluation on 4/4/05 revealed that the volume of the prostate gland was 15.5 grams, which confirmed that the patient was in fact eligible for seed implantation.

In May 2005, the patient went to the Dominican Republic. While there, he underwent non-FDA approved high intensity focused ultrasound, therapy that destroys tissue with rapid heat elevation. When he returned from there, he was next seen on 9/16/05 at yet another medical facility in the United States. He reported that he now had urinary incontinence and sexual dysfunction, which required a high dose of Viagra. His PSA level was 1.4. A body scan was negative for metastasis. On 9/26/06, the plaintiff’s PSA level was unchanged. On 12/5/06, it was 1.8. On 4/27/07, his PSA level was 2.0 and his bone scan was negative for metastasis.

In September 2006, the plaintiff commenced a lawsuit against the urologist who performed the robotic surgery, his professional corporation, the hospital, the pathologist, and two physician assistants employed by the hospital. The plaintiff alleged that the defendant was negligent in performing the RALP by failing to remove the prostate cancer, failing to remove the entire prostate gland, and negligently utilizing the robotic assisted laparoscopic device to perform this surgery. The defendant also was alleged to have failed to review the initial post-surgical pathology slides, as well as monitor the plaintiff’s post-surgical PSA levels. Finally, the plaintiff alleged that the defendant failed to disclose to the plaintiff that he had not removed the entire prostate gland and then failed to perform additional surgery after receiving the elevated post-surgical PSA levels. The plaintiff’s damages included both incontinence and impotence. However, he did not initially have these complaints after the robotic surgery. These complaints appeared only after the plaintiff received the non-FDA approved ultrasound treatment in the Dominican Republic.
When the plaintiff and his wife were deposed, they both expressed anger at the defendant for failing to advise them post-operatively that he did not remove the entire prostate gland. They were credible witnesses. At the time of his deposition, the plaintiff did not appear to have metastasis. His PSA level had also decreased. He was otherwise doing well, with the exception of incontinence and impotence.

The defendant urologist was a competent witness. He was clearly more experienced in performing robotic surgery by that time and appeared confident in his experience. He testified that he had received robotic training from the manufacturer during the first three months of his fellowship in 2003. He did not begin to perform robotic procedures until 2004, when he became an attending. He further testified that, although he had previously performed four to five other robotic procedures as an attending before performing the plaintiff’s surgery, this was only his first or second robotic prostatectomy.

A physician from the defendant’s professional corporation was then deposed. He was questioned about his investigation into the defendant’s training before the defendant was hired. He testified that he had contacted the urology programs which trained the defendant and that he was satisfied by the information he obtained about the defendant’s credentials and experience. However, no one in this practice had ever performed robotic surgery prior to the arrival of the defendant. The defendant PA who assisted at the procedure was then deposed. He had no recollection of that particular procedure. The other co-defendant PA was present only as an observer during the procedure, which was part of his training. Finally, the co-

continued on page 10
defendant pathologist was deposed. She testified that she did notify the defendant urologist that there was no cancer present within the specimen and advised him that the entire prostate gland may not have been removed by him.

The case was reviewed by experts for MLMIC. The urology expert found no liability on the part of the two PAs and the pathologist. However, he was quite critical of the defendant urologist. He opined that the defendant had improperly performed the surgery. He only removed a portion of the prostate gland and left the remainder of the prostate and seminal vesicles in the patient. He opined that the defendant’s anastomosis also did not make sense and felt that the defendant was obviously confused about the anatomy. He suggested that if the defendant had realized what he was doing, he could have converted to an open procedure. Finally, the expert questioned whether the defendant had sufficient training and experience in the use of the robot. According to the hospital’s intake sheet, it appeared that “another physician was proctoring this surgery.” This raised a question as to whether the defendant was even fully credentialed by the hospital for using a robot at the time of the surgery. Additionally, the fact that the defendant was proctored was not reflected in the operative report. He also suggested that although incontinence and impotence are known complications of radical prostatectomy which were discussed pre-operatively with the patient, the plaintiff in fact did not have these symptoms post-operatively. However, the problem defending this case was that, because the defendant had improperly performed the robotic surgery, it led to the need for the plaintiff to undergo further procedures, which did result in injury to the plaintiff.

The case was then reviewed by an outside expert who was knowledgeable in the RALP procedure. He felt it would be very difficult to defend the partial excision of the prostate gland. He also attributed this to the defendant’s lack of experience and training. The expert also suggested that the patient should have been told immediately that some tissue had been left behind and offered further options for treatment. He then would have waited four to six weeks after the receipt of the pathology report to commence any subsequent treatment. Because the outside expert would not be able to effectively convince a jury to “ignore the weaknesses” of this case, the MLMIC reviewer recommended that the case be settled.

The plaintiff’s counsel initially demanded $850,000 to settle this case. After speaking with the plaintiff’s counsel, the defense counsel sensed the plaintiff would accept less than the initial demand. A trial date was scheduled. The trial was adjourned several times while negotiations ensued. Finally, the defense counsel was able to settle the case for $350,000, which included satisfying a Medicare lien of $8,585.99. All of the settlement was paid on behalf of the defendant urologist.

**A Legal & Risk Management Perspective**

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The central question in this case was whether the robotic surgery was appropriately performed. As with the use of any new procedure or device, there is often a prolonged learning curve. Until a physician has had sufficient experience under the eyes of a knowledgeable proctor, there is greater risk of patient injury using a robotic device. In this case, the
urologist was trained for several months by the manufacturer during his fellowship. However, the specifics as to the number of hours of such training, as well as how much of this training incorporated “hands on” experience rather than didactic education, is unclear. Further, there was no mention that this urologist had performed robotic procedures under the supervision of his attendings during fellowship. Finally, although he apparently had a proctor during the robotic procedure, the presence of the proctor was not documented. Therefore, it was unlikely that the urologist was fully credentialed by that facility to perform that particular robotic procedure. During trial, the plaintiff’s counsel would likely have raised the question of whether the defendant had a duty to disclose his lack of sufficient experience and full credentialing to the plaintiff during his informed consent discussion. In fact, the plaintiff made this allegation in the complaint. The defendant’s lack of adequate experience and transparency with his patient was a key problem in vigorously pursuing his defense.

Another issue of concern was the defendant’s possible concealment from the plaintiff of the fact that he had not removed the entire prostate gland. If the defendant intentionally had not disclosed that information to the patient, and he was clearly on notice of this fact, his concealment could have been construed as fraud. If there had been any question about whether the statute of limitations had expired when the plaintiff commenced a lawsuit, the New York State statute of limitations may well have been extended until either the discovery of the fraudulent concealment or one year from the date of discovery of facts which would reasonably lead to the discovery of the fraud, whichever is earlier. Therefore, the defendant would have risked having a medical malpractice lawsuit commenced beyond the usual statute of limitations for malpractice. Further, in 2001, the Joint Commission required disclosure to a patient when there is an unanticipated outcome. Since this was a result which was significantly different than the procedure intended to provide, disclosure was clearly indicated. Additionally, in 2013, New York State required that patients shall be advised of any change in health status, including harm or injury, the cause for the change, and the recommended course of treatment. This was an untoward result and would likely have qualified as an equipment user error resulting in the serious injury of a patient pursuant to the Joint Commission. Thus, the facility should have been notified by the urologist and the event reported to the New York State Department of Health, as well as disclosed to the plaintiff, as soon as the problem was identified.

Finally, defense counsel might have argued that the plaintiff’s treatment in the Dominican Republic was a “superseding intervening cause” of the plaintiff’s injuries. In order to prove causation under this theory, in a lawsuit, one must show that a third party’s misconduct (that of the Dominican Republic providers) played such a significant role in producing the result complained of that the defendant’s negligence was in essence meaningless. Liability would then not be imposed if the defendant’s acts or omissions could not be considered a substantial cause of the events which produced the injury. There would be no proximate cause between the defendant’s acts and the injuries, which is a key element in proving there has been medical malpractice. However, at trial, the plaintiff would likely try to prove that any damages caused by the treatment in the Dominican Republic were not the sole cause of his injuries to such an extent as to relieve the defendant from his own negligence. Rather, the plaintiff would likely attempt to show that there were multiple causes for the injuries, but that they were primarily caused by defendant’s failure to remove the entire prostate gland. This omission, in turn, caused the plaintiff to undergo a variety of other treatments, including that in the Dominican Republic, in order to prevent metastasis from the cancer remaining in his prostate gland.

In summary, this case was very difficult to defend, in part due to the defendant’s initial negligence in performing robotic surgery without sufficient experience, as well as his failure to promptly disclose his negligence to the plaintiff and then provide him with other options in a timely manner.

2. Joint Commission Standard RL.01.02.01.
3. 10 N.Y.C.R.R. § 405.7(b)(8).
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