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CASE REVIEW

A detailed look at New York-specific medical professional liability cases

November 2019

Case Review is published under the auspices of MLMIC Insurance Company's Continuing Medical Education Committee, John Lombardo, MD, Chairperson.

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The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.

CASE STUDY I

Multiple Failures in Care Result in Neurologically Impaired Infant

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The Delivery

A 30-year-old female, gravida 4, para 3, was admitted for induction of labor at 42 weeks gestation. The pregnancy was essentially unremarkable. Following the artificial rupture of membranes at 7:30 a.m., a Pitocin drip was started and the dosage was gradually increased by protocol. At 12:05 p.m., a nurse first noted bleeding. At 12:10 p.m., the obstetrician placed an internal lead after performing a vaginal examination. An episode of bradycardia lasting 11 minutes was noted before recovery to baseline. During that time, the fetal heart rate fell below 100 bpm.

At 12:30 p.m., the obstetrician ordered an epidural anesthesia and left the unit. As the anesthesiologist attempted to place the epidural

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CASE STUDY II

Questionable Eye Care and Records Lead to Large Settlement

Brian Muller
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Early Treatment

A one-month-old female infant was seen by the insured ophthalmologist and diagnosed with congenital cataracts. The physician recommended surgery. Two weeks later, he performed a cataract extraction in the left eye with anterior vitrectomy without complications. By four months of age, the infant was optically corrected with the placement of a contact lens. She

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catheter, the patient developed a leg cramp. Therefore, the epidural needle was removed. Placement was finally achieved at approximately 12:55 p.m., at which time the anesthesiologist also left the unit. The length of time that it took to place the epidural catheter was felt in no way to contribute to the fetal difficulties that subsequently ensued. Decelerations were noted during the 25 minutes that it took to complete placement of the epidural catheter. This was followed by a prolonged deceleration with a decrease in beat-to-beat variability and a slow return to baseline.

At 1:05 p.m., maternal blood pressures decreased to 81/50 following the epidural. The nurse's note reflects that the obstetrician was called and advised of those changes. At 1:10 p.m., the maternal blood pressure was 88/49 and the fetal heart rate was 150 to 160. At 1:15 p.m., the maternal blood pressure was 99/52, but the fetal heart rate was now below 90 bpm. Late decelerations were noted, and the obstetrician was again notified.

The obstetrician arrived at 1:23 p.m. At that time, the maternal blood pressure was 103/63 and the fetal heart rate was below 80 bpm. There were late decelerations with slow recovery and decreased variability on the EFM strips. A vaginal examination revealed the cervix to be 3-4 cm dilated, with bleeding again present. At 1:30 p.m., the fetal monitor showed minimal variability. At 1:35 p.m., the maternal blood pressure was 85/50, and the fetal heart rate was between 70 and 110 bpm. At this time, the nurses noted bright red bleeding. At 1:38 p.m., the obstetrician called for a caesarean section. The anesthesiologist responded and "topped off" the epidural at 1:52 p.m. The patient arrived in the operating room at 1:59 p.m. The fetal heart rate was now below 60 bpm. The first incision was made at approximately 2:12 p.m. and the infant was delivered at 2:15 p.m.

Post-Delivery Observations

The baby boy weighed 8 pounds 9 ounces. He was extremely floppy at birth, with Apgars of 1, 4 and 7 at 10 minutes. Free blood and clots were seen in the uterus at the time of the delivery, which strongly suggested a placental abruption. At two to three minutes of life, the baby was intubated by the anesthesiologist. The pediatrician arrived at 2:24 p.m. He documented chest compressions with a heart rate of 60. He also documented that the baby was still limp and blue and had a poor response to the resuscitative efforts. He suggested that the tube was misplaced, so the anesthesiologist reintubated the baby. The baby's heart rate and color then improved. The anesthesiologist went back to care for the mother until 3 p.m.

At 3:10 p.m., a chest x-ray of the infant revealed that the tip of the tube was directed toward the right mainstem bronchus. The radiologist's impression was that the tube was "malpositioned." There is nothing documented in the medical record that reflects that the tube was subsequently raised. However, a second chest x-ray taken later showed that the tip of the tube was now above the carina. The child was maintained on mechanical ventilation, suffered seizures, and was transferred to a tertiary medical center. An MRI there showed encephalomalacic changes representing hypoxic ischemic encephalopathy. The child suffered from cerebral palsy, with spastic quadriparesis and profound cognitive/communication impairment. He required 24-hour home or institutional care. The baby had no genetic defects upon testing.

Lawsuit and Expert Reviews

The plaintiff's parents commenced a lawsuit on the child's behalf against the hospital. They sued the pediatrician, a non-MLMIC insured, the obstetrician and his partner, both MLMIC insureds, their professional corporation, and the anesthesiologist, who was also a MLMIC insured. The complaint alleged mismanagement of the plaintiff's labor and delivery.

Medical experts in the fields of obstetrics, anesthesiology and pediatrics reviewed this case. The obstetrical reviewer expressed concerns that at approximately 12:05 p.m., the electronic fetal monitoring tracing and the nurse's notes reflected maternal bleeding. The fetal monitor strips showed prolonged, deep variable decelerations and a reduction in beat-to-beat variability. After the epidural was completed at 12:55 p.m., the strips demonstrated a bizarre pattern, with almost complete loss of variability, associated with a baseline of approximately 100 bpm, with multiple short accelerations to 130 bpm. The electronic fetal monitoring strips continued to show ominous signs until approximately 1:40 p.m., when the emergency caesarean section was called. The obstetrical expert opined that the caesarean section should have been called for at around 12:30 p.m., which would have resulted in delivery of the fetus approximately one hour and 15 minutes sooner. The obstetrical reviewers recommended prompt settlement of the lawsuit.

The anesthesiology reviewers opined that the insured anesthesiologist should have questioned the appropriateness of placing an epidural in a patient with bleeding and a fetus in distress. They also advised that he should have stayed with the mother to observe the effects of the epidural, which caused a decrease in blood pressure. They also were extremely critical of the lack of documentation by both the obstetrician and the anesthesiologist. The anesthesia record indicated that the epidural placement at 12:30 p.m. was

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essentially unremarkable. However, the nurse's notes reflect that the catheter was initially removed due to a possible injury to the patient. Further, the anesthesiologist entered no notes in the record regarding topping off the epidural at 1:52 p.m.

The most damaging part of the anesthesia record were the vital signs of the mother taken between 12:30 p.m. and 2:00 p.m. The record showed repeated blood pressure entries of 115/55. However, the nurses had recorded blood pressures of 80-90 systolic. It was not clear whether the anesthesiologist was in attendance with the mother from 12:30 p.m. onward, as the caesarean section was called at 1:38 p.m. and the nurse's notes indicate that the anesthesiologist responded at 1:50 p.m. The anesthesia record also failed to reflect the time of the incision. Additionally, the anesthesiology record was extremely brief regarding the intubation of the infant. However, the nurse's notes indicate that the initial intubation by the anesthesiologist "failed" and that the infant was not successfully intubated until nine minutes after delivery.

This faulty recordkeeping and poor documentation were very damaging to the credibility of the anesthesiologist. Because his credibility was completely compromised, his care could not be supported by an expert witness.

Settlement

The plaintiff's initial demand to settle this matter was $11 million. Eventually, the case was settled for a total of $6.7 million. A total of $4.9 million was paid by MLMIC. All of the policies of the obstetrician were used for the settlement. This included $1.3 million in primary coverage, $1 million in excess coverage through another carrier, and $1.3 million of the policy of his professional corporation. All of the anesthesiologist's policies were used as well. This included his primary policy of $1.3 million and the $1 million in coverage for his professional corporation. He did not have a policy of excess coverage. The non-MLMIC insured pediatrician contributed $750,000 from his policy. The non-MLMIC insured hospital paid $50,000 towards the settlement. Interestingly, this settlement occurred prior to the inception of the New York State Medical Indemnity Fund, to which these parents would have been directed to seek money for future medical expenses and devices.

CASE STUDY I

A Legal & Risk Management Analysis

Donnaline Richman, Esq.
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Cases that involve brain-damaged infants are extremely expensive to resolve. This case revealed multiple legal concerns resulting from the care of both the anesthesiologist and obstetrician that made it very high risk to defend and made settlement imperative for both physicians.

The main allegation against the obstetrician was a failure to recognize an abruption of the placenta in a timely manner. He then failed to order an emergency caesarean section, despite seeing and also being notified of bleeding during the patient's labor. His failure to act in a timely manner, in addition to the lawsuit, could also have subjected him to charges of professional misconduct if this case was reported by the plaintiff to the New York Department of Health Office of Professional Medical Conduct (OPMC).[1]

The obstetrician could also have been charged with patient abandonment.[2] The patient's blood pressures and the fetal heart rates were seriously depressed, yet the obstetrician left the patient. He failed to return to see her for over an hour, despite being called by nurses several times. When he finally appeared, the fetus had already been severely compromised. Therefore, the appearance of a lack of concern for both the patient and fetus, without being able to articulate a rationale for doing so, seriously undermined any possible defense. The obstetrician then had no choice but to settle this case for not only his policy limits and excess insurance coverage, but also for his professional corporation's coverage. As required by law, this settlement was then reported to the National Practitioner Data Bank[3] by MLMIC Insurance Company. Further, the obstetrician was also obligated to update his New York State Physician Profile as a condition of registration renewal under Article 131 of the New York State Education Law. This must be done by all physicians in New York State within six (6) months prior to the expiration date of the physician's registration period.[4]

The anesthesiologist had even more serious deficits in his care. He failed to have and document an informed consent discussion[5] with this patient regarding the epidural anesthesia she was to undergo. He was obligated by law to discuss the risks, benefits, and alternatives to an epidural, including not having an epidural and the risks of the alternatives. However, he failed to both have such a conversation and document the procedure itself. Nor did he document the problems he had starting the epidural. However, because the nurses did document these difficulties, his version of these events that he gave to his counsel directly conflicted with the nurses' notes.

It was suspected that the anesthesiologist inaccurately reflected his treatment on multiple occasions. There were two conflicting anesthesia records and he failed to document the two attempts to start the epidural. These inaccuracies and the prior conflicts with the nurses' notes created suspicion that other aspects of the anesthesia records, such as the blood pressures entered during the emergency surgery, were also not accurate and/or poorly documented. These inaccuracies could be deemed to violate New York State Education Law 6530 (32). This statutory provision requires that a physician maintain a record which accurately reflects the evaluation and treatment of the patient. Additionally, if the physician had in fact altered his records, that may be deemed a potential violation of altering a business record.[6]

Although the anesthesiologist was aware that the patient was bleeding and the fetus was showing significant signs of distress after he started the epidural anesthesia, he, too, left the patient and also failed to contact the obstetrician. This could be construed as patient abandonment if the plaintiff's counsel had reported him to OPMC. And while he claimed that he was never notified of continuing problems by the nursing staff until the caesarean section was called, the nurses' notes clearly contradicted his claims.

Because of all of these deficits in his care, and especially the many alterations in his anesthesia record, it would have been impossible to permit this physician to testify under oath to a jury.

When the anesthesiologist's care was reviewed by experts, they

1. New York State Education Law 6530 (1,2).
2. New York State Education Law 6530 (30).
3. 42 USC 11131 (a) and (b)
4. New York State Public Health Law 2995-a (4).
5. New York State Public Health Law § 2805.
6. New York State Penal Code §175.05

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CASE STUDY II

Questionable Eye Care and Records Lead to Large Settlement

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returned for appropriate follow-up. Her parents were compliant in patching the infant's remaining good eye. After that surgery, she was seen multiple times and all appeared to be going well.

Emergent Development

Approximately one year later, the infant developed a visual problem in her left eye. She presented to a local hospital emergency department with nausea and vomiting. Her ophthalmologist was not consulted at that time. Subsequently, the infant suffered an acute glaucoma attack and her optic nerve was damaged due to elevated pressure.

Five days later, the parents took the child to their own ophthalmologist. That physician dilated the infant's left eye, "breaking the angle closure," so she was no longer having a glaucoma attack. The insured ophthalmologist examined her later that day. He documented that he agreed with the impression of the previous ophthalmologist that the infant had an aphakic pupillary block glaucoma caused by an acute angle closure glaucoma attack.

Two days later, the insured ophthalmologist saw the infant emergently in his office. However, approximately 36 hours elapsed before he returned the infant to the operating room for an evaluation under anesthesia. When he did, he performed a left anterior vitrectomy, a peripheral iridectomy, and an anterior segment surgery for acute angle closure glaucoma.

The ophthalmologist did not dictate or transcribe his operative report until two months after this surgery. He documented that the surgery should not have been done sooner because the infant was not having a glaucoma attack and her cornea was still hazy. He testified that the optic nerve had already been damaged because preoperatively the optic nerve showed damage, swelling and secondary atrophy.

Following the second surgery, the infant's eye healed. A contact lens was manually inserted by the parents and patching was appropriately performed. Unfortunately, the infant's vision did not improve. She was referred to various specialists, including a pediatric glaucoma specialist, a pediatric retinal specialist, and an expert in EPS (extrapyramidal side effects) testing for measurement of VEP (visual evoked potential) and ERG (electroretinography). These specialists all concluded that the optic nerve of the left eye had been irreversibly damaged and that there was nothing more that could be done to regain vision in that eye. The infant was last seen at the office of her ophthalmologist two months after the procedure.

Lawsuit Filed

The parents commenced a lawsuit against the insured ophthalmologist alleging he had failed to timely and properly treat the infant plaintiff's left eye and failed to diagnose and treat the glaucoma and the increased intraocular pressure that affected

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the optic nerve. They claimed that this caused the damage that resulted in her permanent loss of vision. The parents further alleged a lack of informed consent by this physician.

During his deposition, the ophthalmologist testified that the infant's loss of vision in the left eye happened more than ten months after he performed her cataract surgery. Therefore, he testified that it was not related in any way to the successful surgery he had performed. He testified that her problems were actually due to the lack of appropriate treatment she received at the hospital when she presented with symptoms suspicious for glaucoma. He supported his testimony with his documentation that she did not exhibit any signs of glaucoma during the office visit after being seen at the emergency department.

The infant's mother then testified that she had been dilating the infant's eye at home, prior to the follow-up visits. She questioned the ophthalmologist on the follow-up visit as to whether this practice impeded his performing a complete eye examination of the infant. She was assured by him that this was not the case.

Expert Reviews

The MLMIC experts who reviewed the case opined that this patient had a congenital cataract and a secondary strabismus, which virtually ensured the likelihood that the vision in her left eye would never equal that of the right eye. Therefore, it was possible that some or perhaps all of the decreased vision of the left eye may have been due to these factors, and not due to the ophthalmologist missing the diagnosis of angle closure glaucoma. Further, these experts did not believe that the infant's current visual status would interfere with or limit either her ability to learn or future job possibilities.

An independent medical examination was conducted and indicated that the plaintiff's corrected visual acuity in the right eye was 20/25- and 20/100- in the left. The diagnosis from the physician who performed this independent examination was at odds with the diagnosis of several subsequent treating ophthalmologists. During discovery, however, it became apparent that five pages of the insured ophthalmologist's office notes had been rewritten to reflect a more comprehensive evaluation of the infant's glaucoma than was in the original records. At that point, the need to resolve this case before trial became urgent.

The reviewers believed that this child and her parents would make extremely sympathetic witnesses at trial. Further, the credibility of the ophthalmologist was significantly impaired by the alteration of his office records. The case was settled prior to trial by the insured and his practice for $2,100,000.

CASE STUDY II

A Legal & Risk Management Analysis

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Counsel to MLMIC Insurance Company

The MLMIC expert in ophthalmology who reviewed this case found the facts very problematic. Although this child's vision was already highly compromised at birth, the late diagnosis of glaucoma with optical nerve damage had serious lifetime consequences for her.

There were several key legal issues which had a great impact on the resolution of this case. The first concern of the reviewer was that the documentation in this case was seriously deficient. The physician delayed evaluating this patient under anesthesia for 36 hours and documented that this procedure was not emergent. He claimed in the record that the patient's optic nerve had already been damaged, and that the patient was not in fact having an acute glaucoma attack. This was not true. Further, he failed to both adequately document the procedure he performed as well as his rationale for any of his actions. His documentation was clearly self-serving. Additionally, his operative report was not documented until two months after the procedure. Such late documentation of a procedure subjects the physician's credibility and veracity to attack, both during depositions and at trial. Both his false explanation for his delay of 36 hours in examining the patient under anesthesia and late documentation of this procedure made this case indefensible.

Another legal issue was the ophthalmologist's failure to complete and document an informed consent

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discussion with the parents. The informed consent process by law[1] requires a discussion by the physician with the parents of the baby of the risks, benefits and alternatives to the treatment, and the risks of the alternatives, including no treatment. He should have discussed some of the most serious and frequent risks and documented all of this discussion. Therefore, this physician not only failed to have an appropriate and documented informed consent discussion with the parents of the child, he also failed to permit them to ask questions and subsequently address their questions and concerns.

A good history and ophthalmic examination must be performed at each visit so that patients, such as this baby, are properly monitored. Timely review of test results, other consultations, or emergency department visits are critical to permit postoperative complications to be addressed in a timely manner. This did not occur here.

When the ophthalmologist failed to accept responsibility for missing the diagnosis of angle closure glaucoma, he began to "finger point" at others. He blamed the hospital where the diagnosis of glaucoma was actually made, although it was likely that the hospital would claim he was totally responsible for the poor outcome.

To attempt to hide his failure and justify his actions, the ophthalmologist rewrote part of his office record. He claimed that he had performed a more comprehensive examination for glaucoma. Not only was this not true, but it was an alteration of his medical record. By altering the record, he made it impossible to defend the lawsuit. Thus the ophthalmologist's actions caused settlement of an otherwise potentially defensible case. He exposed himself to potential charges of professional misconduct by creating a false record. If this alteration had come to the attention of the plaintiff's counsel, it is likely a complaint would have been made to the Department of Health, Office of Professional Medical Conduct (OPMC).[2] Attorneys for plaintiffs sometimes have their clients contact OPMC to allow OPMC to investigate a potential liability case. If charges of misconduct are then brought against the physician, the plaintiff's case is greatly strengthened.

It is also important to know that it is a misdemeanor to alter a business record.[3] Because a medical record is considered also to be a business record, an alteration of a medical record would fall under the New York State Penal Code. Thus, such an allegation can have a very broad and negative impact on the career of a physician.

With the advent of electronic health records, plaintiffs' attorneys often ask for production of metadata from the physician's computer, in addition to the patient's medical records. This information confirms when an entry is made or is altered or otherwise changed. In this way, the altered and late documentation would inevitably have been discovered by the plaintiff's attorneys, making the defense of an otherwise defensible suit impossible.

1. New York State Public Health Law 2805 (1).
2. New York State Education Law § 6530 (32).
3. New York State Penal Code § 175.05.

CASE STUDY I

A Legal & Risk Management Analysis

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criticized his decision to "top off" the epidural rather than inducing rapid sequence general anesthesia. This action caused further delay in starting the caesarean section. The New York State Health Code at 10 NYCRR § 405.19 provides that an incision for an emergency caesarean should be made within 30 minutes from the decision to perform the surgery. This standard was not met. Of note, this physician also failed to document the actual time of the incision in his anesthesia record.

His documentation regarding the baby's condition at birth and intubation status was also falsified. The nursing documentation showed his difficulty in starting the epidural anesthesia and his incorrectly intubating the baby. If he had testified and made the comments he did to his attorney about his "excellent skills" in intubation and providing epidural anesthesia, the jury might well have punished him for those remarks by rendering a very large verdict against him.

In summary, despite the plaintiff's substantial monetary demands for the care of a severely compromised newborn, settlement of this case by both the obstetrician and the anesthesiologist was necessary to protect them from a judgment which exceeded the limits of all of their policies.

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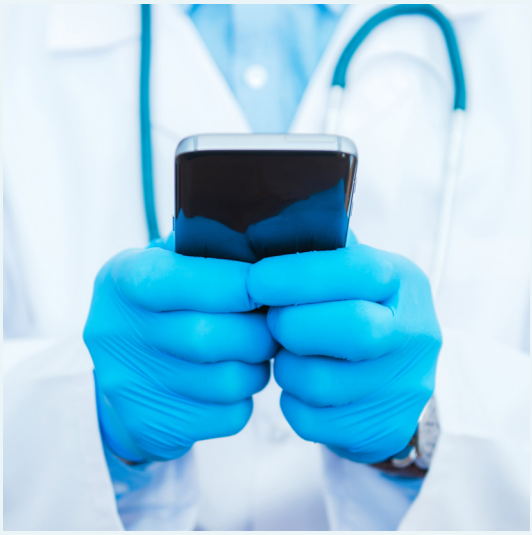

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