Distractions in the Operating Room: A Case Study

"OR Distractions," From Preceding Page

The following case highlights some of the significant challenges in defending anesthesia providers in litigation involving allegations and evidence of distractions in the OR:

The case involved a 53-year-old male with medical history significant for atrial fibrillation and smoking who presented for an elective cardiac atrial fibrillation ablation under general anesthesia. The anesthesia provider performed the pre-anesthesia examination and assigned the patient an ASA III classification.

Shortly after the induction of anesthesia and placement of the endotracheal tube (ETT), the cardiologist performed a transesophageal echocardiogram (TEE) that revealed an ejection fraction of 40–45%. Four minutes into the procedure, the patient's systolic blood pressure dropped into the 80s. The anesthesia provider administered 10 mg ephedrine, but the blood pressure stayed in the 80s, and the pulse rate went up to 180 beats per minute (bpm). The anesthesia provider informed the cardiologist about the changes in vitals, but the cardiologist indicated that he was not concerned about the heart rate because he was trying to locate the source of the atrial fibrillation, and there were no signs of ischemia on the EKG.

The anesthesia provider supported the blood pressure with phenylephrine IV in 200 mcg boluses. He informed the cardiologist of his treatment, and the cardiologist was aware of the events due to the monitors in front of him. The anesthesia provider also lowered the anesthetic inhalational agent (sevoflurane) and gave fluid to maintain blood pressure. The blood pressure was labile and required multiple interventions throughout the case.

The patient's systolic blood pressure dropped into the 60s on two occasions. The anesthesia provider decided to begin a low-dose dopamine infusion to help control the blood pressure, and he notified the cardiologist of his activities. Once he initiated the dopamine infusion, the systolic blood pressure stabilized in the 90s. About 45 minutes later, the blood pressure dropped again and the anesthesia provider increased the dopamine infusion and the phenylephrine boluses, at which point the systolic pressure rose to 110. He continued to communicate his treatment choices to the cardiologist throughout the procedure. Although the cardiologist was aware of the volatile shifts in the blood pressure, the anesthesia provider believed that he was not concerned because he continued with the ablation procedure.

Approximately 15 minutes after the systolic pressure had risen to 110, it again dropped into the low 80s. Phenylephrine administration only assisted in bringing it up for a few minutes, and then it dropped into the 50s and would not increase in response to medications. The EKG showed that the patient's heart was generating electrical impulses, but it became clear that his heart was not beating and he was experiencing pulseless electrical activity (PEA).

A Code was called and the cardiologist suspected the patient was experiencing a cardiac tamponade. Multiple attempts to perform pericardiocentesis were unsuccessful. Another cardiologist arrived to assist and was able to drain 450 to 600 cc of fluid from the pericardial sac. The heart rate was restored and the patient was transferred to ICU. Unfortunately, the patient never recovered from the Code, and was eventually taken off the ventilator and passed away.

The patient's wife and son sued the anesthesia provider, the cardiologist, and the hospital. The patient's family alleged the anesthesia provider failed to: recommend that the cardiologist stop the procedure due to the hemodynamic instability caused by the hypotension, properly evaluate the cause of the hypotension that persisted for over two hours prior to the cardiac arrest, and maintain an acceptable blood pressure. The patient's family alleged further that the anesthesia provider's negligence contributed to the cardiac arrest resulting in hypoxic ischemic brain injury and death.

Defense experts retained on behalf of the anesthesia provider were supportive of his care. The anesthesiology expert believed that the anesthesia provider's treatment of the hypotension met the standard of care, and he appropriately communicated the patient's changing vitals and hemodynamic status to the cardiologist throughout the case. Further, he opined that the anesthesia provider does not have a duty, or even an ability, to stop the procedure as that decision is up to the cardiologist.

Despite the supportive expert witness, during discovery several nurses present in the OR testified the anesthesia provider was texting and reading articles on the Internet throughout the entire case and even during the Code. The anesthesia provider's mobile phone records, however, confirmed the anesthesia provider did not receive or send a text during the procedure. In deposition testimony, the anesthesia provider acknowledged he was looking at emails on his mobile phone during the procedure. The Internet log for the computer in the cardiac catheter lab confirmed that the anesthesia provider was accessing the Internet at various times during the procedure. He last accessed the Internet approximately eight minutes before the Code started. While there was no specific evidence the anesthesia provider was on the Internet during the Code, there was electronic evidence that the anesthesia provider was reading news stories on Yahoo and accessing his personal email account during the procedure.

Based on this evidence, defense counsel opined a jury would likely react very negatively to evidence that the anesthesia provider was accessing the Internet and his personal email in the cardiac catheter lab just moments before the Code. In the face of testimony from multiple nurses that the anesthesia provider was using a mobile phone throughout the procedure, and even during the Code, defense counsel was concerned PPM would be unable to persuasively defend the anesthesia provider given this potentially inflammatory testimony.

Based on defense counsel's evaluation, the anesthesia provider consented to settlement. The parties participated in mediation and the case was settled within the insurance policy limits.

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