Was the Extubation of the Patient the Cause of her Death?

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In last month's bulletin, Miller v. Markowitz, Dalecki and Memorial Hospital For Cancer & Allied Disease, 1 was reviewed with a focus on the issue of informed consent for the EGD procedure. In addition to an allegation of lack of informed consent for the procedure, the patient's executor also alleged that professional negligence against the physicians and the hospital, pleading that the defendants failed to timely "resuscitate and oxygenate" the patient during a code.

Although not named as a defendant, but brought into the suit as an employee of Memorial Hospital, the nurse anesthetist's actions were critical in determining whether her extubation of the patient caused her death.

The nurse anesthetist testified that she assessed the patient after the EGD procedure and found the patient "ventilating and arousable". She also placed her hand over the patient's mouth to make sure the patient was exchanging air. 2 She did not document the exact time of the extubation, however.

Shortly after arriving in the PACU, the patient's heart rate slowed and she appeared pale. A code was called but the code was unsuccessful and the patient died. The autopsy indicated the patient had atherosclerotic cardiovascular disease.

One of the key issues during the resuscitation efforts was whether the intubation during the resuscitation was correctly done. One of the nurses in the PACU testified during her examination before trial ("EBT") that the placement auscultation was "negative", meaning that the nurse anesthetist could not hear breathing sounds. 3

However, many days after the EBT, when the nurse reviewed her EBT, she changed her testimony with regard to the negative auscultation note. The change went from a clear statement that the nurse anesthetist could not hear breathing signs to a statement that the nurse was not able to clearly read her documentation on the CPR record. As a result, she continued that in view of the other documentation in the CPR record, "it is clear that good placement of the endotracheal tube was achieved". 4

A board certified anesthesiologist testified for the defendants. He stated that the nurse anesthetist properly extubated the patient at 4:30 p.m.; that the cardiac arrest at 4:33 p.m. could not have been due to oxygen levels; and that despite the nurse's correction of her testimony, the intubation was successful.

The plaintiff's expert witness, another board certified anesthesiologist, testified that the patient should not have been extubated until after she was "wide awake and gagging on the breathing

tube". He further opined that the fact that the nurse anesthetist put her hand over the patient's mouth to assess breathing indicated that the patient was not wide awake.

The expert further testified that the assumption that the extubation of the patient was at 4:30 p.m., before she was wide awake, caused gastric juice to enter the patient's trachea and bronchial tree because her "protective airway reflex" was not yet back. 5 This condition caused "an intense contraction of circular involuntary muscles around the bronchi" that disrupted the flow of oxygen to the heart and lungs for 14 minutes. This substantial loss of oxygen and eventual cardiac arrest, along with the patient's coronary artery disease, caused the patient's death. In short, the nurse anesthetist breached her standard of care with this patient.

The plaintiff's expert also tesitifed that the resuscitation efforts were inadequate.

As a result of the testimony of both experts, the Court held that the summary judgment requested by the defendants on the professional negligence counts was denied, and the case was to continue in the trial court for a determination as to whether the defendants' actions caused the death of the patient.

There is no reported case decision to date concerning what happened at the trial level after the case was ordered to be continued there. However, the case is an interesting one for several reasons. First, it illustrates the importance of complete and legible documentation in any patient care record. Had the PACU nurse been able to testify with certainty about her documentation, the Court may have ruled differently.

Also of interest in relation to documentation is the fact that the nurse anesthetist *did not* document the exact time of the intubation after the surgical procedure. Again, had she done so, along with details about the patient's condition prior to extubation, the documentation may have changed the outcome of the case.

FOOTNOTES

1. 2011 NY Slip OP 30417 (N.Y. Sp. Ct. 2011).
2. Id., at 3.
3. Id.
4. Id.
5. Id., at 7.

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