Legal Issues in Patient Positioning

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Background

Medical malpractice lawsuits have been a feature in American courts for nearly as long as the United States has existed. Cases have been filed with increasing regularity since 1794, the date of the first recorded medical malpractice suit, but it was not until the 1970s that this litigation began to be perceived as a "crisis."[1] Many states have enacted tort reform measures in an effort to combat rising medical malpractice insurance premiums and to maintain physician populations. Yet medical malpractice lawsuits still pervade court dockets.

According to a 2011 study that examined malpractice data from 1991 through 2005 for all physicians covered by a large, national professional liability insurer, 7.4% of physicians annually had a claim, with 1.6% making an indemnity payment.[2] The mean indemnity payment was $274,887, and the median was $111,749.[3] Breaking down this data by specialty revealed substantial variations in risk measures. Neurosurgeons, at 19.1%, had the highest risk of facing a claim annually, while anesthesiologists were slightly below the claim-risk percentage for physicians across all specialties.[4] Claim risk by specialty did not correlate well with the likelihood of indemnity payment; gynecologists had the highest payment rate while being only the 12th highest among specialties for claim risk.[5] Nor did claim risk correlate with the highest average indemnity payments. Though neurosurgeons were the most likely to face a claim, the highest average payment associated with that specialty ($344,811) was lower than that for pathologists ($383,509) and pediatricians ($520,924), two specialties with low claim risk.[6] The study also considered "outlier awards" or those in excess of $1 million. These awards accounted for less than 1% of all payments, and of the 35 total outlier awards included in the data, anesthesiology accounted for seven.[7]

To gain a better understanding of the liability and indemnity payment risk associated with positioning in neurosurgical procedures, I reviewed data obtained from the ASA Closed

[1] Flemma R. Medical malpractice: a dilemma in the search for justice. Marq L Rev. 1985;Winter; 68(2):240–42.

[2] Jena A, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med. 2011;365(7):632.

[3] *Ibid*., 633.

[4] *Ibid*., 632.

[5] *Ibid*., 632–33.

[6] *Ibid.*

[7] *Ibid*., 633.

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Claims Project (CCP).[8] the CCP recorded 232 neurosurgical claims involving spinal surgery (210) and craniotomies (22) between 2000 and 2016. The CCP categorized these claims into the following outcomes: positioning-related nerve injury (n = 14, 6%); other nerve injury, no evidence of malpositioning (n = 39, 17%); other positioning-related injuries, no nerve injury (n = 22, 9%); postoperative visual loss—ischemic optic neuropathy (n = 28, 12%); and all other neurosurgical claims (n = 129, 56%).

Of the 53 positioning-related and "other" nerve injuries, 47% affected the spinal cord, 21% affected the brachial plexus, and 15% affected the ulnar nerve. These 53 injuries included two deaths, 29 permanent disabling injuries, and 22 temporary or non-disabling injuries. Of the 22 positioning-related injuries where no nerve injury was reported, 10 were skin reactions or pressure sores; seven were eye injuries, including five retinal or vein occlusions, one corneal abrasion, and one claim for ptosis. Liability for each outcome group is summarized in Table 21.1.

Patient positioning thus cannot be overlooked as an area of potential exposure for neurosurgeons, anesthesiologists, and others. The purpose of this chapter is to provide an overview of the law governing medical malpractice and informed consent and to discuss the claims and arguments that have been raised in lawsuits where proper positioning was an issue. However, cases finding no liability on the part of a defendant should not be viewed as a guarantee that the same result will be reached in another court, particularly a court in another state, even under a similar set of facts. Each individual state controls its own tort law, including its own medical practice laws and statutes, and different states impose different requirements on litigants.

Moreover, every case ultimately turns on its own facts. Many of the cases discussed in this chapter may examine only limited aspects of proof because of where the case was procedurally. For example, when a defendant files a motion to dismiss for failure to state a claim (often in the early stages of the case), the court reviewing the motion can consider only what is contained in the pleadings and must presume all of the allegations in the complaint to be true. In other words, the court examines only the legal sufficiency of the complaint, not the strength of the plaintiff's proof or evidence.[9] After engaging in discovery, the defendant may file a motion for summary judgment, which may be granted if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."[10] Though a court does consider proof relating to the merits of a claim in evaluating summary judgment motions, it must view the evidence in the light most favorable to the plaintiff.[11] In contrast to both a motion to dismiss and a motion for summary judgment, jury verdicts are made after both sides have presented their proof at trial and the jury has had the opportunity to consider and weigh all of the evidence and to evaluate the credibility of witnesses.

Medical Malpractice

Medical malpractice (or "health care liability" or "medical negligence," depending on the state) is a category of negligence. As a general matter, to make a prima facie case of medical malpractice, a plaintiff must establish the basic elements of negligence: (1) the defendant owed a duty of care to the plaintiff (e.g., the existence of a physician–patient relationship); (2) the defendant breached that duty; (3) the plaintiff suffered an injury; and (4) the defendant's breach of his duty was the actual and proximate cause of the plaintiff's injury. The plaintiff typically has the burden of

[8]The text of this chapter was submitted for prepublication review and approved by the ASA Closed Claims Project Committee.

[9]E.g., *Webb v. Nashville Area Habitat for Humanity, Inc.*, 346 S.W.3d 422, 426 (Tenn. 2011).

[10]E.g., Tenn. R. Civ. P. 56.04 (2016).

[11]E.g., *Amos v. Metro. Gov't of Nashville & Davidson County*, 259 S.W.3d 705, 710 (Tenn. 2008).

Table 21.1 ASA closed claims project liability for outcome groups in neurosurgical claims (Reproduced with permission from the ASA closed claims project committee)

		Positioning-related nerve injury	Other nerve injury (no evidence of malpositioning)	Positioning-related injuries (no nerve injury)	ION	All other neurosurgical claims
Number of cases	Total *N* in each group	14	39	22	28	129
Appropriate anesthetic care	Less than appropriate	1 (8%)	6 (17%)	7 (44%)	5 (24%)	53 (47%)
	Appropriate	11 (92%)	29 (83%)	9 (56%)	16 (76%)	60 (53%)
	Total	12	35	16	21	113
Claim paid? (any payment, including surgeon or hospital)	Yes	4 (29%)	20 (51%)	13 (59%)	17 (61%)	77 (60%)
	No	10 (71%)	19 (49%)	9 (41%)	11 (39%)	51 (40%)
	Total	14	39	22	28	128
Total payment adjusted to 2015 dollars[a]	Median	$120,450	$672,500	$123,300	$438,400	$396,000
	Percentile 25	$38,700	$300,375	$26,800	$268,000	$137,000
	Percentile 75	$635,186	$1,241,500	$330,000	$825,000	$967,500
	# of payments	4	20	13	17	77

[a]Due to small sample size, median and IQ ranges should be interpreted with care. Median and interquartile ranges exclude claims with no payment ($0). Claims with missing data were excluded

proving all of these elements by a preponderance of the evidence.

Standard of Care

The defendant's duty of care to the plaintiff is measured by the "standard of care." In medical malpractice actions, the standard of care is not perfection or even best practice.[12] Instead, it looks to whether a defendant's conduct was "reasonable." But how "reasonableness" is measured varies from state to state.

Tort law in many jurisdictions has, to some degree, mirrored the standardization of training, licensing, and certification requirements for physicians and other medical personnel. A majority of states, including Alabama, California, Florida, Georgia, Mississippi, Missouri, Ohio, Texas, and Wisconsin, apply a national standard of care.[13] One court has described this standard as follows:

> Each physician may with reason and fairness be expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States, to have a realistic understanding of the limitations on his or her knowledge or competence, and, in general, to exercise minimally adequate medical judgment.[14]

In contrast, a minority of states apply some version of the "locality rule," which looks to the standard of care for the same or similar community in which a defendant practices. Arizona, Virginia, and Washington apply a statewide standard of care; Arkansas, Illinois, Kansas, Maryland, Michigan, Minnesota, Nebraska, North Carolina, North Dakota, Oregon, and Tennessee apply a same or similar community standard; and Colorado, Louisiana, Montana, Pennsylvania, and South Dakota apply a similar community standard for general practitioners and a national standard for specialists.[15]

For example, Tennessee statute requires that a plaintiff prove "[t]he recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred."[16] Any witness who is being offered as an expert on the standard of care must be licensed to practice a profession or specialty "relevant to the issues in the case" in either Tennessee or in a contiguous bordering state, absent a showing that an appropriate expert witness is not available within those geographical restrictions.[17] Experts must also demonstrate familiarity with the medical community in which the defendant practices or a similar community by either firsthand knowledge or by educating themselves on the characteristics of the medical community at issue.[18] Yet, even though Tennessee continues to follow the locality rule, its courts have been influenced by the trend toward national standardization:

> Therefore, expert medical testimony regarding a broader regional standard or a national standard should not be barred, but should be considered as an element of the expert witness' knowledge of the standard of care in the same or similar community. Contrary to statements made in the dissent, this recognition is neither a dilution nor a relaxation nor an invitation of reliance on a national or regional standard of care. It is simply a common sense recognition of the current modern state of medical training, certification, communication, and information sharing technology, as demonstrated in the numerous instances of sworn testimony offered by medical experts in the above-reviewed cases, as well as the thoughtful analysis and discussion by courts in several other jurisdictions, that the consideration of such testimony is justified.[19]

[12] E.g., *Bozarth v. State LSU Med. Ctr./Chabert Med. Ctr.*, 35 So. 3d 316, 324 (La. Ct. App. 2010); *Siirila v. Barrios*, 248 N.W.2d 171, 192 (Mich. 1976).

[13] Lewis MH, Gohagan JK, Merenstein DJ. The locality rule and the physician's dilemma. JAMA. 2007;7(23):2635.

[14] *Hall v. Hilbun*, 466 So. 2d 856, 871 (Miss. 1985).

[15] Lewis et al. *supra* note 13, at 2635.

[16] Tenn. Code Ann. § 29-26-115 (2017).

[17] *Ibid.*

[18] *Shipley v. Williams*, 350 S.W.3d 527, 552-53 (Tenn. 2011).

[19] *Ibid.*, 553 (internal citations omitted).

Plaintiffs have attempted to use internal rules, policies, and protocols of hospitals to establish the standard of care, but many courts have held that these policies, without more, do not conclusively prove the standard of care.[20] This precedent has emerged, in part, to avoid penalizing hospitals that set aspirational policies and procedures.[21] Recommended practices by medical associations also do not, in and of themselves, establish the standard of care. However, like internal hospital policies, such recommendations may be used to support expert testimony.[22]

Congress has recently passed legislation rejecting the notion that federal health care program guidelines, standards, and regulations establish a duty of care or the standard of care in medical malpractice actions. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) includes the following provision: "[T]he development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim."[23] Therefore, the Patient Protection and Affordable Care Act (PPACA) and Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act and their associated standards and regulations (such as quality incentives, conditions of participation, etc.) cannot alone be used to prove the standard of care.[24]

With this background, it is not surprising that case law reflects a variety of expert opinions on standard of care for patient positioning. What is consistent, however, is the suggestion that everyone—from the surgeon to the anesthesiologist to the nursing personnel—may share some role or responsibility in ensuring a patient is properly positioned for surgery.[25]

In *Dierolf v. Doylestown Hospital,* et al. (Pennsylvania), the plaintiff alleged that she suffered a dropped foot following a maxillofacial procedure in the supine position that lasted over six hours. The plaintiff's expert claimed that the defendant anesthesiologist may have placed the straps in an excessively tight manner; that the anesthesiologist should have placed padding under the plaintiff's knee to keep the knees flexed and to avoid compression of the peroneal nerve; and that the plaintiff's leg may have rotated outward during the procedure and exerted pressure on the nerve for an extended period of time. Both the defendant anesthesiologist and her expert witness testified that the use of padding under the knee was contraindicated because the padding itself could cause pressure on the peroneal nerve and create blood pressure issues. The defendant anesthesiologist also testified that, though she could not check the strap during the course of the operation because the surgical drapes needed to remain in place for sterility, she had inspected the straps before the procedure began and saw no indication of excessive tightness. The defendant anesthesiologist also stated that she was "primarily responsible" for avoiding positioning-related nerve injury. The jury found for the defendants.[26]

[20] E.g., *Doe v. St. Francis Hosp. & Med. Ctr.*, 72 A.3d 929, 963–64 (Conn. 2013); *Moyer v. Reynolds*, 780 So. 2d 205, 208 (Fla. Dist. Ct. App. 2001); *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965); *Wuest v. McKennan Hosp.*, 619 N.W.2d 682, 689 (S. D. 2000); *Prewitt v. Semmes-Murphey Clinic, P.C.*, No. W2006-00556-COA-R3-CV, 2007 Tenn. App. LEXIS 149, at *47–48 (Tenn. Ct. App. Mar. 23, 2007); *Reed v. Granbury Hosp. Corp.*, 117 S.W.3d 404, 413 (Tex. App. 2003); *Auer v. Baker*, 63 Va. Cir. 596, 600 (Va. Cir. Ct. 2004).

[21] *Wuest*, 619 N.W.2d at 689.

[22] *Estate of Lepage v. Horne*, 809 A.2d 505, 516 (Conn. 2002); *Kipp v. United States*, 880 F. Supp. 691 (D. Neb. 1995); *United States ex rel. Mikes v. Straus*, 84 F. Supp. 2d 427, 432–33 (S.D.N.Y. 1999).

[23] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114–10, § 106(d)(1), 129 Stat. 87, 142 (2015).

[24] *Ibid*., § 106(d)(2); *see Bain v. Colbert County Nw. Ala. Health Care Auth.*, No. 1150764, 2017 Ala. LEXIS 9, at *50 fn.8 (Ala. Feb. 10, 2017).

[25] *Accord* Martin JT. General principles of safe positioning. In: Martin JT, Warner MA, editors. Positioning in anesthesia and surgery. 3rd ed. Philadelphia: W. B. Saunders; 1997. p. 6.

[26] *Dierolf* vs. *Doylestown Hosp.,* et al. Pennsylvania jury verdict review & analysis 1989;7(5).

In *Neidert v. University of Minnesota Medical Center* (Minnesota),[27] the plaintiff alleged that, following an eight-hour heart transplant surgery, he developed compartment syndrome in his left hand due to malpositioning during surgery. In support of his claim, the plaintiff submitted affidavits from his expert witnesses, an anesthesiologist and an orthopedic surgeon, which stated that everyone in the operating room was responsible for proper positioning and padding of the patient and for examining the patient's extremities. On summary judgment, the defendants challenged these experts' affidavits on several grounds, including that the experts' opinions did not differentiate between the different medical personnel present in the operating room (nurses, anesthesia staff, surgeons, etc.) but merely treated them as a group. The court denied the defendants' summary judgment motion,[28] but a jury ultimately returned a defense verdict.[29]

In *Barber v. Dean* (Texas),[30] the plaintiff underwent a CABG procedure that lasted over six hours. Following the harvesting portion of the procedure, the anesthesiologist, aided by several nurses, "tucked" the patient's arm. The plaintiff later complained of pain, burning, numbness, and weakness in his left hand and arm, and he was diagnosed with a left ulnar nerve lesion and ulnar cubital syndrome. The court quoted the opinion of the plaintiff's expert, an anesthesiologist experienced with cardiac surgical procedures, on the standard of care:

> *The applicable reasonable, prudent and accepted standards of care for … Dr. [Tauriainen] [and] Dr. Dean … involved a shared responsibility on the part of each of these surgeons, the physician assistant, and nurses to properly position and pad [Malcolm's] left and right upper extremities before the start of the CABG surgical procedure, during the left radial artery harvest, after the left radial [artery] harvest and during the remainder of the surgery in order to prevent peripheral neuropathies to [Malcolm's] upper extremities.*
>
> Of the major nerves in the upper extremities, the ulnar nerve and brachial plexus nerves are and were the most common nerves to be at risk of injury and to become symptomatic and lead to major disability of a patient during and after the perioperative period. Improper surgical patient positioning and padding of upper extremities were well-known causative factors in the development of surgical patients' ulnar neuropathies as of 2004 and such risks had been known by the surgical, physician assistants, hospital, and operating room nursing communities in the United States for many years. As of 2004, reasonably prudent anesthesiologists, cardiovascular and cardiothoracic surgeons, general and traumatic surgeons, physician's professional associations, registered nurses, and physician [] assistants were or should have been aware that surgical patients in supine positions were at risk of developing ulnar nerve injuries and neuropathies during surgery due to external ulnar nerve compression or stretching caused by malpositioning and improper or inadequate padding during surgery. *Prevention of perioperative peripheral neuropathies to [Malcolm], including his left upper extremity, was preventable by proper positioning and padding of his left arm and hand.*
>
> Dr. Moss, with the cooperation of nurses Alexander and Syptak, should have positioned [Malcolm's] right and left upper extremities in a manner to decrease pressure on the postcondylar groove of the humerus or ulnar groove. When his arms were tucked at the side, the neutral forearm position with elbows padded would have been appropriate. When his left upper extremity was abducted on an armboard, that extremity should have been either in supination or a neutral forearm position. His arm should have been extended to less than ninety degrees. They should have applied padding materials such as foam sponges, eggcrate foam, or gel pads, to protect exposed peripheral nerves in [Malcolm's] left arm, particularly at the site of his elbow and left ulnar groove. *Thus, after Drs. [Tauriainen] [and] Dean … harvested [Malcolm's] left radial artery from his left upper extremity extended on an armboard, they, together with Dr. Moss, and nurses Alexander and Syptak, should have assured that [Malcolm's] left upper extremity was returned to his side in a neutral forearm position and padding of his left elbow and any bony prominences should have been performed to protect his left ulnar nerve and prevent the risk of a left upper extremity neuropathy to the nerve. Also, Drs. [Tauriainen] and Dean … should have assured and followed procedures so that [Malcom's] left upper extremity was positioned in a neutral forearm position and properly padded to prevent the risk that any of the surgeons or*

[27] *Neidert v. Univ. of Minn. Med. Ctr.*, No. 27-CV-08-11856, 2009 Minn. Dist. LEXIS 112 (Minn. Dist. Ct. July 6, 2009).

[28] *Ibid.*, *2–9 & 39.

[29] *Neidert v. Univ. of Minn. Med. Ctr.*, No. 27-CV-08-11856, 2009 Minn. Dist. LEXIS 105 (Minn. Dist. Ct. Oct. 26, 2009).

[30] *Barber v. Dean*, 303 S.W.3d 819 (Tex. App. 2009).

assistants could come in contact or lean on his left arm during the surgical procedure.[31]

The defendant surgeons filed a motion to dismiss the case, arguing that the plaintiff's expert was not qualified to opine as to the standard of care for cardiovascular and thoracic surgeons and that his report failed to state with specificity the applicable standard of care. Though the trial court granted the defendants' motion to dismiss, the Texas Court of Appeals reversed, finding that the plaintiff's expert was qualified to render opinions as to whether the surgeons had deviated from the standard of care regarding the proper positioning and padding of the plaintiff's arm and that the report specifically stated that all the medical and nursing personnel "owed the same duty to ensure the proper positioning and padding."[32] The case was allowed to proceed.

In *Padilla v. Loweree* (Texas),[33] the plaintiff alleged that she had sustained a brachial plexus injury as a result of improper positioning during a gynecological surgery. In support of her claim, the plaintiff submitted an affidavit by her expert witness, an orthopedic surgeon, that stated that the surgeon was ultimately responsible for the patient's positioning; that the anesthesiologist was responsible for the patient's positioning while the surgeon was operating; and that after the procedure, the surgeon and the anesthesiologist were both responsible for ordering appropriate monitoring and care. The defendants filed a motion to dismiss on the basis that the plaintiff's expert was not qualified to opine as to the standard of care for positioning a patient during gynecological surgery. The trial court denied the defendants' motion, and the Texas Court of Appeals affirmed, noting that "the proper positioning and padding of a patient's arm during the gynecological surgical procedure is not a subject exclusively within the knowledge or experience of a physician specializing in such surgery."[34] This finding appears to be based on the perception that positioning principles are the same in orthopedic and gynecological surgical procedures. The case was allowed to proceed. According to court records, the anesthesiologist was later dismissed on summary judgment, and a nonsuit was taken as to surgeon and surgical center.

Breach of Standard of Care, Causation, and *Res Ipsa Loquitur*

After establishing the standard of care, a plaintiff must show the defendant deviated from it, causing an injury to the plaintiff. These are issues that typically require expert testimony and that may ultimately be determined based on which party's expert the jury finds more credible.

Plaintiffs often seek to apply the doctrine of *res ipsa loquitur* (Latin for "the thing speaks for itself") to establish breach of the standard of care and causation. This approach has been used in cases involving post-anesthesia neuropathies,[35] perhaps because these types of neurological injuries are not always associated with the types of surgeries they follow.[36] As one commentator has noted: "All too often, patients, family members, and consulting or subsequent health care providers make this causation leap of logic without considering alternative causes."[37]

Under *res ipsa*, a jury may infer that a defendant was negligent—even if the plaintiff cannot show what actually happened—if the plaintiff's injury ordinarily would not occur absent negligence.[38] *Res ipsa* does not conclusively establish that the defendant was negligent; it merely allows a jury make this inference from the circumstances. A defendant can rebut this inference by

[31] *Ibid*., 830–31 (italics in original).

[32] *Ibid*., 822, 826–27, 830–31.

[33] *Padilla v. Loweree*, 354 S.W.3d 856 (Tex. App. 2011).

[34] *Ibid*., 859, 861–64, 866.

[35] E.g., *Horner v. N. Pac. Benefit Ass'n Hosps., Inc.*, 382 P.2d 518 (Wash. 1963); *Getch v. Bel-Park Anesthesia Assoc.*, 1998 Ohio App. LEXIS 1920 (Ohio Ct. App. Apr. 15, 1998); *Fitzgerald v. El Camino Hosp.*, No. H032094, 2009 Cal. App. Unpub. LEXIS 7181 (Cal. Ct. App. Sept. 3, 2009).

[36] *See Getch*, 1998 Ohio App. LEXIS 1920, at *1–2.

[37] White KJ. Medicolegal considerations. In: Martin JT, Warner MA, editors. Positioning in anesthesia and surgery. 3rd ed. Philadelphia: W. B. Saunders; 1997. p. 330.

[38] Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 17 cmt. a (2010).

presenting proof that he was not negligent or that the plaintiff's injury was not the result of that defendant's negligence.[39] For example, evidence that the injury at issue is an inherent risk of a surgical procedure may rebut *res ipsa.*[40]

In *Fitzgerald v. El Camino Hospital* (California),[41] a plaintiff alleged that during a thoracoscopic dorsal sympathectomy, her arm fell off an armboard, causing a brachial plexus injury. A jury returned a verdict in favor of the defendants. The plaintiff appealed, claiming that she had established the *res ipsa* conditions and that the defendants had failed to rebut the inference of negligence. The appellate court affirmed the verdict, concluding that there had been conflicting testimony on whether a brachial plexus injury could have occurred during this surgical procedure absent negligence.[42]

In *Seavers v. Methodist Medical Center* (Tennessee),[43] a plaintiff claimed her right ulnar nerve was injured due to negligent positioning while she was being treated for bilateral viral pneumonia in the hospital ICU. The plaintiff's expert neurologist stated that, though he could not offer conclusive proof of causation, the plaintiff's injury was the type that would not have occurred in the absence of negligence by the nursing staff, who were responsible for positioning and turning the plaintiff's body.

The trial court dismissed the plaintiff's claim on summary judgment, concluding that the *res ipsa* theory was not available, and the Court of Appeals affirmed. At that time, Tennessee was one of a minority of states that restricted the use of *res ipsa* in medical malpractice cases to those involving injuries where lay jurors could apply their own common sense to infer negligence, such as where a sponge had been left in a patient's body.[44] If "the subject matter of the alleged malpractice requires a scientific exposition," expert testimony was necessary and the *res ipsa* inference was not permitted.[45] However, the Tennessee Supreme Court reversed, extending the availability of *res ipsa* in medical malpractice cases. The Court concluded that the *res ipsa* conditions could be met even where the injury at issue is outside the jury's common knowledge:

> This is especially true in medical malpractice cases where, as here, a claimant suffers a subtle nerve injury while heavily sedated and under the exclusive care of a hospital nursing staff. Claimants often have no knowledge of what happened during the course of medical treatment, aside from the fact that an injury occurred during that time. In cases where the standard of care or the nature of the injury requires the exposition of expert testimony, such testimony may be as probative of the existence of negligence as the common knowledge of laypersons. The use of expert testimony in that regard serves to bridge the gap between the jury's common knowledge and the complex subject matter that is "common" only to experts in a designated field. With the assistance of expert testimony, jurors can be made to understand the higher level of common knowledge and, after assessing the credibility of both the plaintiff's and defendant's experts, can decide whether to infer negligence from the evidence.[46]

Damages

If a plaintiff establishes the elements of negligence, she must then prove the damages she is seeking to recover. This may include economic and noneconomic damages. Though states may differ somewhat in how they define each category, economic damages are generally described as objectively quantifiable losses, such as medical expenses and lost wages, while noneconomic damages, including pain and suffering and loss of consortium, cannot be objectively quantified. Tennessee's statute differentiates between the two types of damages as follows:

> "Economic damages" means damages, to the extent they are provided by applicable law, for: objectively verifiable pecuniary damages arising

[39] *Ibid*., § 17 cmt. g.

[40] *Ibid*., § 17 cmt. e.

[41] *Fitzgerald v. El Camino Hosp.*, No. H032094, 2009 Cal. App. Unpub. LEXIS 7181 (Cal. Ct. App. Sept. 3, 2009).

[42] *Ibid*., *2–7, 33–44.

[43] *Seavers v. Methodist Med. Ctr.*, 9 S.W.3d 86 (Tenn. 1999).

[44] *Ibid*., 91–93.

[45] *Ibid*., 92.

[46] *Ibid*., 94–95.

> from medical expenses and medical care, rehabilitation services, mental health treatment, custodial care, loss of earnings and earning capacity, loss of income, burial costs, loss of use of property, repair or replacement of property, obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and other objectively verifiable monetary losses [.]
>
> "Noneconomic damages" means damages, to the extent they are provided by applicable law, for: physical and emotional pain; suffering; inconvenience; physical impairment; disfigurement; mental anguish; emotional distress; loss of society, companionship, and consortium; injury to reputation; humiliation; noneconomic effects of disability, including loss of enjoyment of normal activities, benefits and pleasures of life and loss of mental or physical health, well-being or bodily functions; and all other nonpecuniary losses of any kind or nature.[47]

Though not objectively quantifiable, noneconomic damages awards may be substantial. In *Steele v. Ft. Sanders Anesthesia Group, P.C.* (Tennessee),[48] a plaintiff underwent a decompressive surgical laminectomy to address some mild neurological problems she was experiencing as a result of arthritis-related compression of the spinal cord in her neck. The surgeon elected to perform the surgery in the seated position. When the plaintiff awoke from surgery, she was paralyzed from the neck down.

Prior to the surgery, the anesthesiologist documented a preoperative examination in the plaintiff's chart, but his entry did not mention the plaintiff's diagnosis, the reason for her surgery, her preoperative average blood pressure, what the surgical procedure would be, or that her spinal cord would be under compression. In the preoperative holding area, another anesthesiologist placed a central line and made an entry in the plaintiff's chart, without referring to the plaintiff's diagnosis or that her spinal cord would be under compression. A third anesthesiologist administered anesthesia to the plaintiff in the operating room before turning care over to a CRNA, who, after approximately 15 min, turned the plaintiff's care over to a second CRNA, who administered anesthesia for the remainder of the surgery. Neither CRNA had ever administered anesthesia in a neurosurgical procedure before. The plaintiff's blood pressure dropped during the surgery, and the second CRNA, who administered anesthesia for the majority of the operation, took no action other than to reduce the level of the anesthetic.

The case was first tried in 1992, and the jury found the neurosurgeon who performed the operation not negligent. The jury also found that the anesthesia group, which employed the three anesthesiologists and two CRNAs, had been negligent, but a mistrial was entered when the jury could not agree on causation.

The case was tried again in 1993 as to the liability of the anesthesia group. The proof showed that the anesthesia group deviated from the standard of care by:

> [F]ailing to recognize a special anesthetic risk faced by plaintiff Mrs. Steele; failing to record necessary information regarding the patient's condition on the chart for reference by others as needed in order to recognize and properly evaluate the anesthesia risk by allowing a person with inadequate skill, knowledge, and experience to administer anesthesia to Mrs. Steele; allowing an excessive number of people to participate in Mrs. Steele's care which increased confusion and decreased communication; failing to give adequate fluids during the surgery; and failing to maintain adequate blood pressure, even though the blood pressure could have been easily raised to an acceptable level with prompt treatment.[49]

Expert witnesses for both sides agreed that operating in the seated position presents an increased risk of ischemic injury to the spinal cord and that a person whose spinal cord is under compression would be more susceptible to ischemic injury. The jury awarded the plaintiff $5,600,809.90 as damages and also awarded the plaintiff's husband $2,000,000 for loss of consortium. The trial court suggested a remittitur in the loss of consortium judgment in the amount of $800,000, which reduced the damages award on that claim to $1,200,000. The plaintiff accepted the remittitur under protest.

[47] Tenn. Code Ann. § 29-39-101 (2017).

[48] *Steele v. Ft. Sanders Anesthesia Group, P.C.*, 897 S.W.2d 270 (Tenn. Ct. App. 1994).

[49] *Ibid.*, 275.

Both parties appealed. The defendant claimed the jury verdict so exceeded the range of reasonableness that the trial court should have granted a new trial. The plaintiff argued that the remittitur was made in error and that the original jury verdict should be reinstated. The Court of Appeals affirmed the judgment of the trial court in all respects, finding that the proof at trial supported a substantial loss of consortium award and that the award after the remittitur was within the range of reasonableness.[50] Notably, however, this case was decided before Tennessee adopted caps on noneconomic damages awards.

Many states have enacted laws limiting the amount of noneconomic damages a plaintiff can receive in medical malpractice actions and other tort actions.[51] These damages may be capped as low as $250,000 or as high as $1,500,000.[52] For example, in Tennessee, a plaintiff generally cannot recover in excess of $750,000 in noneconomic damages.[53] Where a jury finds there has been a "catastrophic loss"—which includes a spinal cord injury resulting in paraplegia or quadriplegia —noneconomic damages are capped at $1,000,000.[54] However, these caps do not apply to actions where the defendant acted intentionally to harm the plaintiff; the defendant intentionally falsified or destroyed records that contained material evidence; the defendant was under the influence of alcohol or drugs; or the defendant's acts resulted in his being convicted of a felony.[55]

Plaintiffs have brought constitutional challenges to these statutes in various states.[56] Courts in Alaska, California, Indiana, Louisiana, Nebraska, Ohio, West Virginia, and Missouri have upheld their state damages caps.[57] However, damages caps have been invalidated in Florida, Georgia, Illinois, and Wisconsin.[58] Courts in some states, including Tennessee, have, to date, declined to rule on the constitutionality of damages caps on the basis that the issue is not yet ripe; that is, no case involving a plaintiff verdict in excess of the statutory cap has yet been presented for their review.[59]

A plaintiff may also be awarded punitive damages under certain circumstances. The purpose of punitive damages is "not to compensate the plaintiff but to punish the wrongdoer and to deter the wrongdoer and others from committing similar wrongs in the future."[60] The availability of punitive damages varies from state to state. In Tennessee, punitive damages are available only if a plaintiff proves by clear and convincing evidence that the defendant acted "maliciously, intentionally, fraudulently, or recklessly."[61] Tennessee also caps punitive damages awards at the greater of two times the total amount of compensatory damages awarded, or $500,000.00. However, these caps do not apply in cases where a defendant had a specific intent to seriously injure a plaintiff; the defendant intentionally falsified, destroyed, or concealed records containing material evidence to evade liability; the defendant was under the influence of alcohol or drugs; or the defendant's acts resulted in his being convicted of a felony.[62]

Limitations on Medical Malpractice Actions

The time period within which a plaintiff may bring a medical malpractice action is restricted

[50] *Ibid*., 272–75, 282–84.

[51] *See generally* Avraham, Ronen, Database of State Tort Law Reforms (5th) (May 2014). U of Texas Law and Econ Research Paper No. e555. Available at SSRN: https://ssrn.com/abstract=902711.

[52] See Stein A. Toward a new theory of medical malpractice. Iowa L. Rev. 2012; 97:1253 (citing Cal. Civ. Code § 3333.2(b) (West 2010) and Fla. Stat. Ann. § 766.118(3)(b)).

[53] Tenn. Code Ann. § 29-39-102(a) (2017).

[54] *Ibid*., § 29-39-102(b).

[55] *Ibid*., § 29-39-102(h).

[56] Stein, *supra* note 52, at 1254.

[57] *Ibid*., 1254 n.291; *Dodson v. Ferrara*, 491 S.W.3d 542 (Mo. 2016).

[58] Stein, *supra* note 52, at 1254 n.1291; *N. Broward Hosp. Dist. v. Kalitan*, No. SC15-1858, 2017 Fla. LEXIS 1277 (Fla. June 8, 2017).

[59] *Clark v. Cain*, 479 S.W.3d 830 (Tenn. 2015).

[60] *Hodges v. S.C. Toof & Co.*, 833 S.W.2d 896, 900 (Tenn. 1992) (citation omitted).

[61] Tenn. Code Ann. § 29-39-104(a)(1) (2017).

[62] *Ibid*., § 29-39-104(a)(5) & (7).

by state statutes of limitations and statutes of repose. A statute of limitations sets the time in which a lawsuit must be filed after a cause of action accrues; if the plaintiff does not file suit within the prescribed time period, she is deemed to have waived her claim.[63] "Thus, the barring of the remedy is caused by a plaintiff's failure to take reasonable steps to assert the cause of action within the time afforded by the statute."[64] Statutes of limitations for medical malpractice cases may range from one[65] to three years.[66]

The date a cause of action accrues is not always the date the medical procedure giving rise to an alleged injury was performed. If the plaintiff reasonably did not discover her injury until some time after the medical procedure, the cause of action is deemed to have accrued on the date of discovery or on the date the injury should have reasonably been discovered. States may also provide for other circumstances that toll, or suspend, the running of the statute of limitations period. One such example is when the plaintiff is a minor or mentally incompetent.[67]

In contrast to statutes of limitations, statutes of repose abolish a cause of action if a plaintiff has not filed suit within a prescribed time after the negligent act occurred, regardless of whether the alleged negligence was discovered or should have reasonably been discovered within that time period. As one court has explained: "Statutes of repose are … not designed, as are statutes of limitations, to necessarily allow a 'reasonable' time in which to file a lawsuit. A statute of repose might theoretically cut off a claim filed within the period allowed by the relevant statute of limitations."[68] Statutes of repose thus serve the purpose of increasing availability of insurance and reducing risk and uncertainty of liability for physicians and other medical practitioners.[69] Statutes of repose for medical malpractice actions may range from three[70] to ten years.[71]

As with statutes of limitations, states have made provision for certain exceptions to their statutes of repose. For example, Tennessee permits plaintiffs to bring medical malpractice lawsuits outside the state's three year statute of repose if a defendant has fraudulently concealed evidence of his negligence.[72]

Informed Consent

Medical malpractice claims are often accompanied by claims for lack of informed consent. Informed consent cases typically involve situations in which a patient authorized a procedure but claims that the physician failed to inform her of any or all of the inherent risks.[73]

Though a defendant may not have been negligent in performing the procedure, he may still be found liable for inadequate informed consent if the plaintiff establishes nondisclosure, causation, and injury.[74] What is required to prove these elements differs across states. To determine adequacy of consent, some states inquire whether the undisclosed risks were such that they "could have influenced a reasonable person in making a decision to give or withhold consent."[75] Other states focus on whether "the information provided to the patient deviated from the usual and customary information given to patients to procure consent in similar situations."[76]

With regard to causation, the majority of states apply an objective standard: "If adequate disclosure could reasonably be expected to have caused [a prudent person in the patient's position] to decline the treatment because of the

[63] E.g., *Lee v. Gaufin*, 867 P.2d 572, 575 (Utah 1993).
[64] *Ibid.*
[65] Tenn. Code Ann. § 29-26-116(a) (2017).
[66] S.C. Code Ann. § 15-3-545 (2016).
[67] E.g., Tenn. Code Ann. § 28-1-106.
[68] *Lee*, 867 P.2d at 576 (citation omitted).
[69] *Ibid.* (citation omitted).
[70] Tenn. Code Ann. § 29-26-116.
[71] Mo. Rev. Stat. § 516.105 (2017).
[72] Tenn. Code Ann. § 29-26-116.
[73] *Blanchard v. Kellum*, 975 S.W.2d 522, 524 (Tenn. 1998).
[74] *See*, e.g., *Ibid.*, 123; *Foster v. Traul*, 175 P.3d 186, 192 (Idaho 2008).
[75] Tex. Civ. Prac. & Rem. Code § 74.101 (2015).
[76] *Blanchard*, 975 S.W.2d at 524; *see also* Tenn. Code Ann. § 29-26-118.

revelation of the kind of risk or danger that resulted in harm, causation is shown[.]"[77] A minority of states apply a subjective standard, in which causation is established solely by patient testimony that she would not have consented to the procedure had she been advised of the risk in question.[78]

Informed consent has been an issue in a number of cases involving ischemic optic neuropathy following a spinal procedure. In *Foster v. Traul* (Idaho),[79] a plaintiff sought damages against an anesthesiologist, alleging he had experienced bilateral posterior ischemic optic neuropathy (PION) following a back surgery. The plaintiff's medical malpractice claims were dismissed on summary judgment, but he was allowed to proceed with his lack of informed consent claim. The defendant filed a subsequent motion for summary judgment as to this claim, which the trial court granted. However, the Idaho Supreme Court reversed, finding that, based on the affidavits of the parties' respective experts, there was a genuine issue of fact as to whether the plaintiff was injured as a result of the defendant's failure to disclose the risk of PION. The experts agreed that PION occurred in a certain percentage of patients following back surgery, that PION was a risk of the procedure, and that the plaintiff sustained that injury.[80]

In *Nemcik v. United States* (New Jersey),[81] a plaintiff brought suit for medical malpractice and lack of informed consent after being diagnosed with PION following a multilevel spinal fusion surgery. The Court found that, at the time of the surgery, it was not the standard of care for anesthesiologists to inform their patients about the risk of PION:

> The Court finds that while the anesthesiologists who attended to plaintiff were responsible for advising Plaintiff about the risks associated with the anesthetic agents and procedures they would be using throughout the course of the surgery, they were not responsible for informing plaintiff about the risks associated with the surgery itself, such as PION. Moreover, the standard of care for anesthesiologists in 2002 did not mandate that they inform their patients that postoperative vision loss was a risk of spine surgery. Anesthesiologists are generalists in their field and cannot be expected to have knowledge of the risks of each and every kind of surgery. Even [plaintiff's expert anesthesiologist] testified that while it would be prudent to tell a patient of the risk, there was no ASA standard that an anesthesiologist must disclose the risk. Furthermore, the risk factors for PION, such as a lengthy spine surgery in the prone position, are not in the control of the anesthesiologists.[82]

The Court further found that a reasonably prudent person in the plaintiff's position would have undergone the procedure even if he had been informed of the risk of PION. In making this determination, the Court focused on the plaintiff's spinal deterioration and pain levels, the rarity with which PION occurred (between 0.03% and 0.1%), and the fact that the plaintiff testified that had he been told of the risk of PION he would have only "hesitated" about having the surgery. The Court ruled in favor of the defendant on all claims.[83]

In *Dacey v. Huckell* (New York),[84] which was decided in 2015, a plaintiff underwent a lumbar decompression and fusion of levels L1 to S1. When the plaintiff arrived in the operating room, the anesthesiologist secured his airway, anesthetized him, and applied a "Dupaco pillow" to his face before moving him into a prone position on a specialized "Jackson" table. After the six and a half hour procedure was completed, the plaintiff was returned to the supine position, and the pillow was removed from his face. It was then observed that the plaintiff had developed pronounced facial edema. The plaintiff was later diagnosed with transient ischemic optic neuropathy secondary to

[77] *Canterbury v. Spence*, 464 F.2d 772, 791 (D.C. Cir. 1972); *see also Ashe v. Radiation Oncology Assocs.*, 9 S.W.3d 119, 122 fn.1 (Tenn. 1999) (summarizing the states that have adopted the objective standard).

[78] *Ashe*, 9 S.W.3d at 122.

[79] *Foster v. Traul*, 175 P.3d 186, 192 (Idaho 2007).

[80] *Ibid.*, 188 & 192–94.

[81] *Nemcik v. United States*, No. 05-1469, 2008 U.S. Dist. LEXIS 51784 (D. N. J. July 8, 2008).

[82] *Ibid.*, *39–40.

[83] *Ibid.*, *6–7 & 40–42.

[84] *Dacey v. Huckell*, No. 42471, 2015 N. Y. Misc. LEXIS 372 (N. Y. Sup. Ct. Feb. 11, 2015).

hemodynamic compromise. The defendants' expert opined that the incidence of vision loss during non-ophthalmological surgery is so rare that failure to disclose this risk does not constitute a deviation from the standard of care. The plaintiff's expert disagreed. The Court found that there was a genuine issue of fact as to whether the standard of care required disclosure of this risk as well as whether a reasonable patient in the plaintiff's position would have chosen to proceed with the surgery even if this risk had been disclosed. The case was allowed to proceed against the surgeon and the anesthesiologist.[85] According to court records, the suit was settled prior to trial.

Recent Federal Legislative Efforts at Medical Malpractice and Health Care Liability Reform

Though tort reform efforts have generally been concentrated at the state level, federal lawmakers have recently made several efforts to reduce the number of medical malpractice and other health care liability lawsuits or to otherwise limit the possible recovery to plaintiffs in these cases. The latest is the "Protecting Access to Care Act of 2017," which was introduced in the House of Representatives by Rep. Steve King (R-Iowa) on February 24, 2017.[86] In its current form, the bill would apply to any medical malpractice or health care liability action, whether brought in state or federal court, "concerning the provision of goods or services for which coverage was provided in whole or in part via a federal program, subsidy or tax benefit."[87] As such, it would appear to cover suits arising out of "health care products or services paid for at least in part by programs such as Medicare, Medicaid, a subsidy under the Affordable Care Act (ACA), Veterans Administration-provided health care, or the Employee Retirement Income Security Act of 1974."[88]

The bill includes the following provisions:

- The statute of limitations for health care lawsuits would be the *earlier* of one year after the claimant discovers (or reasonably should have discovered) his injury or three years after the date of injury or the date of completion of the health care treatment at issue. No health care lawsuit could be brought after three years had passed from the earlier of the date of injury or the completion of the treatment at issue (except in cases involving fraud, intentional concealment, or leaving a foreign object in a patient). However, this would not preempt any state law that provides for a shorter statute of limitations or that establishes a statute of repose.
- Noneconomic damages would be capped at $250,000. However, these caps would also not preempt any state law setting the amount of damages available in a health care lawsuit.
- Expert witnesses must be licensed to practice in the state where the injury at issue occurred or in a contiguous bordering state and practice a profession or specialty which would make that person's expert testimony "relevant to the issues in the case," thus imposing a version of the locality rule. If a defendant is a board-certified specialist, any expert witness testifying regarding the standard of care for that defendant must also be board-certified in the same specialty. Expert witnesses would also be subject to any state-specific requirements with respect to their qualifications.
- A plaintiff must file with his complaint an affidavit of merit signed by a health care provider stating that the defendant breached the standard of care, what actions should have been taken or omitted by the defendant, and how the defendant's actions caused the plaintiff's injury.[89]

[85] *Ibid.*

[86] All actions H.R.1215—115th Congress (2017–2018) [Internet]. Available from: https://www.congress.gov/bill/115th-congress/house-bill/1215/all-actions-without-amendments?r=1.

[87] Protecting Access to Care Act of 2017, H.R. 1215, 115th Cong., 1st Sess. (2017) (as referred to the Senate).

[88] H.R. Rep. No. 115-55, at 36 (2017) (internal footnotes omitted).

[89] Protecting Access to Care Act of 2017, *supra* note 87.

This bill, as outlined above, passed the House on June 28, 2017, and is now pending in the Senate. However, the likelihood the bill will progress further is low. The bill is opposed by numerous consumer and public interest groups as well as the American Bar Association.[90] Several physicians' groups, including the Association of American Physicians and Surgeons and the American Academy of Family Physicians, have objected to provisions similar to those in the bill that are included in the Trump Administration's proposed budget.[91] Previous bills seeking to impose limits on medical malpractice actions in the states have been unsuccessful.[92]

One piece of failed legislation that sought to go extraordinarily far in standardizing medical malpractice litigation was the Empowering Patients First Act of 2015,[93] which was introduced in the House on May 13, 2015, by Tom Price. The bill proposed that the Secretary of the U.S. Department of Health and Human Services "provide for the selection and issuance of clinical practice guidelines for treatment of medical conditions" with a "physician consensus-building organization" and other physician specialty organizations. If a defendant in a medical malpractice lawsuit established by a preponderance of the evidence that treatment was provided consistent with these clinical practice guidelines, she could not be held liable unless the plaintiff then established the defendant's "liability" by a much higher clear and convincing evidence standard. The bill further provided for grants to states to develop their own "health care tribunals" to resolve malpractice claims through nonjudicial expert review panels and subsequent administrative review process. If, after going through this process, a party was dissatisfied with the outcome, that party could file his claim in a state court, but he would have to forfeit any award he received during the administrative review process. If the expert panel or administrative tribunal previously made a finding in favor of the health care provider on compliance with the clinical practice guidelines or on any other element of a medical malpractice claim, the defendant would be entitled to judgment as a matter of law in the state court unless the plaintiff could produce clear and convincing evidence to the contrary.[94] This bill never made it to a vote.[95]

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[90] H.R. Rep. No. 115-55, at 35.

[91] Dickson V. Providers want trump to stay out of tort reform. Modern Healthcare [Internet]. 2017 May 24 [cited 2017 Jun 18]. Available at: http://www.modernhealthcare.com/article/20170524/NEWS/170529947/providers-want-trump-to-stay-out-of-tort-reform.

[92] *See* Protecting Access to Healthcare Act, H.R. 5, 112th Cong. 2d Sess. (2012); Actions overview H.R.5—112th Congress (2011–2012) [Internet]. Available from https://www.congress.gov/bill/112th-congress/house-bill/5/actions?r=1.

[93] Empowering Patients First Act of 2015, H.R. 2300 §§ 401 *et seq*., 114th Cong., 1st Sess. (2015).

[94] *Ibid.*

[95] All Actions H.R.2300—114th Congress (2015-2016) [Internet]. Available from https://www.congress.gov/bill/114th-congress/house-bill/2300/all-actions?r=1.