Routine Procedure, Unprepared System: A Closed Case Review

By Erika Roberts, JD

This closed case review began like many pain management procedures conducted across America. A familiar patient. A modest dose of Versed. A routine procedure. Unfortunately, when an unexpected complication arose, a rapidly evolving emergency tested a clinical team's readiness and ended in a tragic loss.

The patient, Michael Jameson[1], arrived at Dr. Charles Clover's office for what both anticipated would be another straightforward pain management procedure. Dr. Clover had been treating Mr. Jameson for his chronic back pain for many years. Mr. Jameson had previously undergone a lumbar medial branch block with IV sedation with Dr. Clover, and this procedure was the second one planned. He was on a complex medication regimen, including chronic pain medications, a morphine pain pump, and other pain medications.

On the day at issue, the medical assistant, Jasper Crace, managed the intake process but failed to conduct or document a medication review and did not obtain Mr. Jameson's signature on a sedation consent form. He started the IV, drew up 2.5 mg of Versed, showed the syringe to Dr. Clover to confirm the dosage, and administered the medication

for situational anxiety. Mr. Jameson was placed faced down on the fluoroscopy table at the start of the procedure. His body was supported for comfort and to allow access along the spine, and Dr. Clover used fluoroscopic imaging to mark the appropriate levels before needle placement. The procedure was completed without any noted complications.

Dr. Clover remained in the room for several minutes afterward, observing Mr. Jameson and conversing with Mr. Jameson's family member, who was also present. He reported that the patient appeared stable, was breathing comfortably, and had oxygen saturation in the upper 90s. He then left to see his next patient, and Mr. Crace oversaw recovery.

Shortly after, Mr. Crace attempted to rouse Mr. Jameson, who did not respond. The wife testified that she was the first to notice he was not breathing and that his lips appeared blue. Mr. Crace and another MA moved Mr. Jameson to a recovery stretcher while he remained facedown. Mr. Crace called out for help and then went to get Dr. Clover. Unbeknownst to Dr. Clover, Mr. Crace had removed the IV and pulse oximeter.

When Dr. Clover returned, Mr. Jameson had been turned over and already had a nasal trumpet placed with oxygen applied. He had no palpable pulse, prompting the initiation of CPR. Dr. Clover began airway maneuvers, including a jaw thrust, while instructing staff to call 911, bring the crash cart, and locate another anesthesiologist (Dr. Alan Conway) for assistance. Dr. Clover attempted intubation twice, but each attempt resulted in esophageal placement, likely due to Mr. Jameson's difficult airway anatomy. He resumed bag mask ventilation between attempts. Dr. Conway also attempted intubation without success. During this time, oxygen saturation readings no longer registered on the monitor.

Dr. Clover established IV access during the code and administered 1 mg of epinephrine per ACLS protocol. Additional medical assistants assisted with chest compressions and bagging. EMS arrived within minutes and ultimately achieved a return of spontaneous circulation.

Mr. Jameson was transported by EMS to a hospital, where he remained hospitalized for several days. During that time, his neurological condition did not improve. Dr. Clover visited him in the ICU and attempted to stay informed, though the family later requested no further updates. Mr. Jameson ultimately passed away from complications of an anoxic brain injury. No autopsy was performed.

The Jameson family's shock and grief evolved into anger, and they directed their frustration toward Dr. Clover and the clinic, whom they perceived as ultimately responsible for Mr. Jameson's safety. The medical records revealed that neither Mr. Crace nor Dr. Clover documented a day of procedure medication review or confirmed the timing of the morphine pump bolus. The sedation consent form was incomplete, and the clinic's policies on monitoring, vital sign documentation, and post sedation observation were not followed. The lack of contemporaneous code documentation was also noted.

A healthcare liability lawsuit was filed against Dr. Clover and the pain clinic. The plaintiffs (Mr. Jameson's wife and their children) alleged that inadequate monitoring, delayed

recognition of respiratory distress, and deficiencies in the emergency response led to the respiratory arrest, anoxic brain injury, and eventual death.

As the suit progressed, the parties moved through depositions, expert review, and exchange of opinions. Plaintiff's counsel emphasized the family's emotional loss and concerns about monitoring practices and emergency readiness. Certain testimony, particularly from Mr. Crace, highlighted inconsistencies in documentation and workflow. In response, the defense emphasized Dr. Clover's longstanding relationship with the patient, his prior uneventful experience with the same procedure, and expert opinions that the small dose of Versed administered could not, by itself, account for the respiratory arrest. Dr. Clover followed ACLS protocol during the resuscitation, and the return of spontaneous circulation would not have been possible without the combined efforts of Dr. Clover, Dr. Conway, and the clinic staff. Ultimately, the parties reached a resolution that reflected the uncertainty of the facts, disputed causation theories, and the seriousness of the outcome.

Key Takeaways

1. **Routine procedures still require reliable systems.** Even familiar patients and low dose sedation can become high risk when documentation, communication, or workflow processes are inconsistent.
2. **Medication reconciliation must be verified and recorded.** A day of procedure review is especially critical for patients with complex pharmaceutical regimens.
3. **Consent and monitoring policies must be followed every time.** Incomplete forms and gaps in documentation increase both clinical and legal vulnerability, even if the procedure itself is uneventful.
4. **Clear delegation does not replace oversight.** Even where medical assistants can manage recovery, physicians may still be held responsible for ensuring staff are trained and prepared for emergencies.
5. **Emergency readiness determines outcomes.** Effective resuscitation requires available equipment, defined roles, and practiced response. When an event occurs, an unprepared system can magnify its impact.

This closed case highlights how unexpected complications can reveal gaps in even well? intentioned and experienced clinical teams. No single misstep likely caused the outcome; rather, a sequence of errors, communication gaps, and unpracticed processes exposed vulnerabilities at a critical moment. When all members of the care team, regardless of role, share a clear understanding of clinic policies, monitoring expectations, and emergency response workflows, patient safety remains the priority, even during routine procedures.

[1] *Names, some facts, and other details have been altered to respect the privacy of the individuals involved.*

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