

A Cautionary Tale



By Jeff Williams, JD

Smart phones and other handheld devices are ubiquitous in our society. They are used in the medical community for professional and personal purposes continuously throughout the day. With the increasing use of these devices to communicate about patients, the line can be crossed not only as to liability concerns, but also privacy concerns.

Susan Dunbar^[1] was a forty-four-year-old married mother of one. She lived with her adult daughter, Mattie, and second husband, Matt Dunbar. As a result of a severe beating at the hands of her biological father when she was an infant, Mattie was left with permanent, severe mental and physical deficits. While Mattie's biological father spent many years in prison, Susan remarried to Matt, who was by all accounts a good man. The two undertook the responsibility of caring for Mattie, a non-verbal, partially blind adult with severe mental deficits.

Susan lived with persistent lower lumbar pain for several years. She finally decided to seek treatment for this issue from her primary care physician. An MRI was subsequently scheduled to diagnose the problem. Other than the back pain, she had a history of obesity,

prior stroke, hypertension, and suspected sleep apnea.

On the day that the MRI was scheduled, Susan became very anxious about the prospect of undergoing the MRI. Upon her arrival at the hospital for the MRI, Susan told a staff member that she was claustrophobic and was experiencing a heightened level of anxiety about the process. Anesthesiologist Dr. Amanda Means evaluated Susan and noted her to be a suitable candidate for monitored anesthesia care. She also spoke to Susan about her anxiety and decided it was safe to perform the MRI while Susan was sedated. The sedation was 150 mg of propofol. Additionally, one milliliter of fentanyl was administered by IV due to her complaints of back discomfort. Certified Registered Nurse Anesthetist Joseph Gardner administered the anesthesia and would accompany Mrs. Dunbar into the MRI room to physically monitor the patient. An MRI tech would also be in the room.

Just prior to the MRI, Susan took a selfie with her cellphone and sent two consecutive text messages to her husband:

Susan: “I love you!”

Matt: “Love you, what’s going on?”

Susan: “I. V. and wait.”

Additionally, before the MRI she posted a picture of her daughter and husband on Facebook with the caption:

“Getting an MRI – family here to support me! They are putting me to sleep. I’m really nervous.”

Also, just prior to the MRI the following text message exchange took place between Dr. Means and CRNA Gardner:

Dr. Means: “They’re just getting her ready now. She’s extremely nervous”

CRNA Gardner: “Total overreaction”

Dr. Means: “HA HA. Typical”

Mrs. Dunbar entered the MRI room accompanied by CRNA Gardner and was placed in the MRI scanner. Mr. Gardner was monitoring her oxygen levels with an O₂ sensor and was also observing her on an MRI-compatible monitor. Although capnography to monitor her end-tidal CO₂ was available for purposes of monitoring, it was not used. Capnography would have offered reliable, real-time feedback about the status of the patient’s condition.

After the MRI had begun, Mrs. Dunbar’s oxygen saturation levels (“sats”) appeared irregular. CRNA Gardner had access to the patient’s head and performed a jaw thrust procedure, which appeared to stabilize her oxygen saturation levels momentarily. Just

minutes later her sat levels again fell to a concerning level in the upper 80s. CRNA Gardner asked the MRI tech to stop the MRI scan and bring the patient out. To increase the oxygen levels, he retrieved a nasal trumpet and oxygen mask that was located outside of the MRI room. Mrs. Dunbar's sats again stabilized. Approximately four minutes later, her sats began to drop again, this time into the mid-80s. CRNA Gardner then retrieved and placed a laryngeal mask airway ("LMA"). The patient was struggling. The MRI tech brought CRNA Gardner an Ambu bag (manual resuscitator), so that oxygen could be provided to the patient in a more forceful manner. As Susan Dunbar's condition continued to deteriorate, she was removed from the MRI room. CRNA Gardner then used his cell phone to call Dr. Means, who responded immediately. Another nurse had become involved and observed that the patient was no longer breathing. A code was called.

CPR was started. To be sure the patient was not experiencing an adverse reaction to Fentanyl, an IV-push of Narcan was administered. Although initial attempts at establishing an airway were unsuccessful, Dr. Means was eventually able to do so. The patient was successfully resuscitated. Later, the records would indicate that from the time the MRI scan started to the time when she was resuscitated, thirty minutes passed. Susan Dunbar had suffered an anoxic brain injury. With the consent of the family, life support was removed a few days later.

The family filed a lawsuit against Dr. Means, CRNA Gardner, and the hospital alleging wrongful death. The allegations against Dr. Means were failure on her part to appropriately evaluate the patient, failure to be physically present during anesthesia, failure to assure the patient's oxygenation, failure to appropriately monitor, and failure to ensure timely and appropriate resuscitative efforts. The allegations against CRNA Gardner included failure to ensure the patient's oxygenation, failure to appropriately monitor the patient, and failure to recognize and timely respond to a medical emergency.

In every case in which there is an allegation of medical negligence, the plaintiff must put forth competent experts in the same field that the defendants were practicing at the time the alleged negligence occurred. Here, the plaintiff produced an anesthesiologist and a certified registered nurse anesthetist to testify that there were deviations from the standard of care. It became clear as the case developed that the primary target of the case was CRNA Gardner.

The evidence would show that capnography to monitor the patient's end-tidal CO₂ was readily available for use during the MRI. Choosing not to use capnography became a major issue in the case. Further, there appeared to be an appreciable delay from the time Mrs. Dunbar's condition was deteriorating in the MRI, to the time she was removed from the machine.

Plaintiff's experts were going to testify that the standard of care required better monitoring of the patient during the MRI. The two criticisms that became the focus of the case were that CRNA Gardner should have chosen to utilize the available capnography to monitor the patient's end-tidal CO₂ and should have responded in a more timely manner to the patient's respiratory distress. Both experts would testify that the standard of care required

the use of capnography to monitor her end-tidal CO₂.

As to the lack of monitoring with capnography, the Plaintiff's experts zeroed in on the patient's comorbidities, especially sleep apnea. The comorbidities, they argued, combined with the use of fentanyl and propofol, proved to be a fatal combination. The Plaintiff's theme in the case was that Mrs. Dunbar's condition was fragile, and, therefore, she should have been monitored more closely.

During the pendency of the suit, Plaintiff's counsel requested all text messages exchanged between any of the patient's medical caregivers to be produced. This is a common request in civil litigation. The text messages were produced, and Dr. Means and CRNA Gardner were questioned about them during their depositions. Did the text messages have an adverse effect on the patient's care or condition? No. Did the text messages have an adverse effect on the defense of the case? Absolutely. At a minimum, the text messages were an unnecessary distraction in a wrongful death case. All medical professionals should assume that text messages, e-mails, and any other recorded communications could become the focus of litigation. Plaintiff's counsel would certainly attempt to use the text messages against them.

In addition to the wrongful death damages that the family was allowed to recover in the suit, state law allowed the family to recover damages related to the continuing care of Mrs. Dunbar's daughter, Mattie, for the rest of her life. This caused the potential damages recoverable to multiply. This unusual wrinkle in the case provided for a challenging defense which was fraught with peril if tried before a jury.

At its most basic level, this case involved a 44-year-old patient who underwent an outpatient MRI and ended up dying due to complications of the sedation used during the procedure, which would be difficult for a jury to reconcile. Given the nature of this case, all parties agreed to mediate the matter. Ultimately, it settled without the necessity of trial.

This story is a cautionary tale. Medical practitioners should assume communications through text messaging, e-mail, and posts on social networks can be used against you in court. Here, Plaintiff's counsel intended to use Mrs. Dunbar's own social media posts just before her death to evoke the jurors' sympathetic emotions. Conversely, it was anticipated that plaintiff's counsel was also going to try to use the text messages between Dr. Means and CRNA Gardner to arouse negative sentiment amongst the jury.

In cases like this one, a healthcare provider's attorney will make arguments to the judge in an attempt to exclude such text messages from being seen and heard by the jury on the basis that the messages are overly prejudicial and lack relevance. A judge, however, is considered the "gatekeeper" of evidence and may or may not allow the text messages into evidence based on certain evidentiary rules and laws. In other words, there is no guarantee that this kind of evidence will be excluded from the jury's consideration.

Many medical practitioners do not use a secure messaging system to send text messages regarding their patients. They simply use their phone to send the messages like everyone

else. Be forewarned, this might constitute a breach of HIPAA and various state laws regarding patient confidentiality. Although text messaging is not specifically prohibited by HIPAA, all patient's PHI (Protected Health Information) must be appropriately safeguarded.

For more on this evolving topic, a video presentation by SVMIC's Director of Risk Education, Jeff Woods, J.D., titled "[Practicing in the Age of Electronics](#)" can be viewed in the Resources section of the [Vantage](#)[®] policyholder portal.

[1] Names have been altered.

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