

Preventive Action

The Quarterly Risk Management Newsletter for Policyholders of APAC

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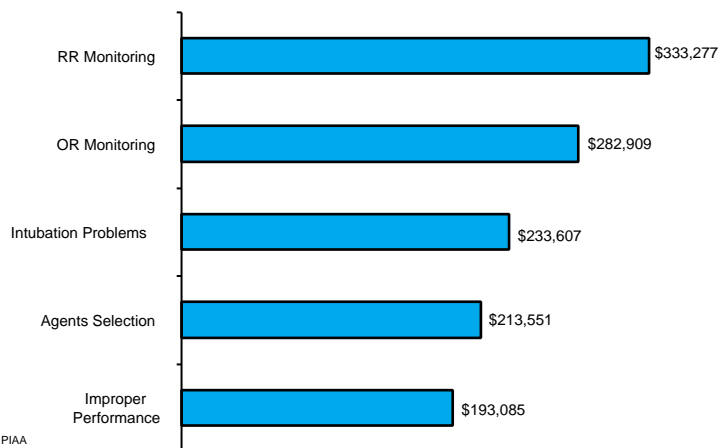
ANESTHESIOLOGY CLAIMS - EVALUATION AND STRATEGIES

By Cliff Rapp, Vice President, Risk Management, FPIC

Recent national closed claims data from the Physician Insurer's Association of America (PIAA) reveals that anesthesiology ranks in the top 10 of all specialties by claims frequency. In 2002, anesthesiology ranked 7th of all medical specialties in terms of indemnity paid. According to the PIAA, 34 percent of claims closed on behalf of anesthesiologists resulted in an indemnity payment to the patient and the average indemnity, per physician, soared to \$362,880.(1) Knowledge of the prevalent issues within these claims data can facilitate a proactive approach to risk reduction.

In terms of risk analysis, respiratory complications are the most frequent problems encountered in anesthesiology claims. Hypoxemia is the most expensive complication, with placement or maintenance of an ET tube the most common etiology. Esophageal intubation, with a corresponding inability to adequately oxygenate and ventilate

Five Most Expensive Misadventures Anesthesiology



account for over 25 percent of claims. Noteworthy is the fact that mortality or permanent CNS damage resulted in 90 percent of these claims, a factor in anesthesiology's above average claim severity.

The following risk management strategies can significantly reduce professional liability exposure:

RISK: Failure to obtain adequate informed consent.

STRATEGY: Describe the specific anesthesia plan recommended and provide options and alternatives before the patient is sedated. Do not delegate the informed consent discussion. Advise the patient of the specific risks and benefits. Modify standard, written consent forms when necessary for risks

and complications specific to the patient. Include a disclaimer for dental injury.

RISK: Negligent induction of anesthesia.

STRATEGY: Confirm and document the correct position of airway/ endotracheal tube. Accurately document induction technique and sequence. Note any problems encountered and all attempts at tube placement. Provide documentation of appropriate supervision of CRNA's.

RISK: Negligent performance of regional, spinal and epidural anesthesia.

STRATEGY: Confirm spinal level in conjunction with preoperative records and consent forms. Document with specificity catheter type, insertion and

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APAC publishes Preventive Action on a quarterly basis as a service to its policyholders. Information in this publication does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained in this newsletter are generalized and may not apply to all practice situations. APAC recommends you obtain legal advice from a qualified attorney for a specific application to your practice. The information should be used as a reference guide only.

For comments, questions, or to obtain additional copies contact the APAC Risk Management Department at 866-294-6014, ext. 3016. rm@fpic.com

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adequacy of line placement.

RISK: Failure to properly monitor the patient intra-operatively.

STRATEGY: Confirm that protective measures such as eye protection and positioning aides are in place. Document adherence to ASA monitoring practice standards. Document accurate times to support that oxygenation and tissue perfusion were properly monitored. Note the patient's response to drugs administered and all interventions. Document ventilation via CO2 analysis/respiratory volume, and pulse via pulse oximetry, palpation and auscultation.

RISK: Failure/delay in diagnosis and management of complications.

STRATEGY: Document with specificity recognition and intervention measures when hemodynamic or respiratory complications are encountered. Document the patient's condition at time of transport to the Recovery Room.



While these risks do not comprise all exposures, they identify prevalent misadventures and allegations encountered in malpractice claims against anesthesiologists. Simple but effective strategies aimed at prevention of adverse outcomes also facilitate validation of quality care – an essential component in successfully defending malpractice claims. Contact the APAC risk management department for additional information and loss prevention programs designed specifically for the practice of anesthesiology and pain management.

(1) PIAA Data Sharing System Report Period 021, Cumulative 1/1/85-6/30/02.

REPORT CLAIMS PROMPTLY

The importance of reporting potential and actual claims promptly cannot be overstated. Late reporting may not only jeopardize your coverage, but undermine your defense. It is essential that APAC be contacted as soon as possible when legal notices pertaining to your professional liability are received. Virtually all legal notices require a response or action of some kind within a statutory timeframe. In Florida, service of suit papers, such as a *summons and complaint*, require that an answer and appearance be filed on your behalf within 20 days of the service. Failure to do so could result in a default judgment that may effectively forfeit a defense – and your professional liability coverage. Receipt

of a *Notice of Intent* will commence a presuit investigative period. Failing to timely report such notice compromises the timeframe necessary to investigate and defend the claim being advanced. If production of certain information set forth by the notice is not made within the required timeframe, affirmative defenses you may be entitled to may be lost.

Report potential or actual claims to APAC by contacting Maria Del Valle at:

APAC
600 N. Pine Island Road, Suite 250
Plantation, FL 33324
Toll free phone: 1-866-294-6014
Local phone: 954-577-2721, ext. 12.
Fax: 954-577-2725

A VALUABLE ASSET: APAC RISK MANAGEMENT SERVICES

In addition to having the best professional liability coverage and services available, policyholders of APAC are afforded the most comprehensive risk management products and services offered. Our "Partners in Prevention" program provides effective risk management and loss prevention services designed to avoid claims, disciplinary actions and encourages your participation

Contact APAC's Risk Management Department to learn more about these services or visit our website at www.apacinsurance.com

RISK MANAGEMENT SERVICES

□ On-site risk management surveys

General practice description: physician demographics, training, hospital affiliations; staff demographics; policies; patient population served

Office layout and appearance

Pharmaceuticals and supplies storage & handling

Equipment services and checks

Laboratory level, scope of services

Waste disposal

Office surgery scope

Patient contact: telephone, fax, e-mail, appointments, medical advice, answering service, prescription refills, waiting time, billing & collection, emergency procedures

Managed Care process review

Medical Record Documentation

OHSA, ADA, AHCA Compliance Plans

Written report citing strengths and weakness with recommended action plan

Follow-up determination of action plan implementation

HIPAA privacy rule compliance

□ Education

CME Risk Management lectures for physicians, surgeons and dentists

Specialty Specific Risk Management Programs

Staff and Physician in-service education on communication,

documentation, risk management principles, and loss prevention

FMA CME accredited Home Study Course

Specialized lecture programs

□ Risk Management Consultations

Individualized guidance and consultations of risk management and legal issues

□ Risk Management Group Programs

Written risk management plan

Training of designated risk manager

Incident reporting form

Reporting of claims

□ Risk Management Reference Source

Comprehensive risk management manual "A Reference Tool For Risk Managers"

"Florida Administrative Codes and Statutes" guidebook

FPIC Claim & Risk Management Reference Guides:

Medical Records Do's and Don'ts

The Lawsuit

The Deposition

License Investigation Defense Coverage

Terminating the Doctor/Patient Relationship

Early Diagnosis Steering Committee educational booklets entailing: Unstable Angina; Breast Abnormalities; Colorectal Conditions

Office Manager's and Administrators guide:

"Risk Management Principles for The Medical Office Staff"

□ Quarterly Newsletters

Risk management publication for anesthesiology

"Preventive Action"

□ Website Risk Management Resource

www.apacinsurance.com

SIMPLE, BUT EFFECTIVE LOSS PREVENTION... Immediately before induction re-evaluate the patient and your anesthesia plan in conjunction with preoperative and pre-anesthesia consent forms.



LOSS PREVENTION

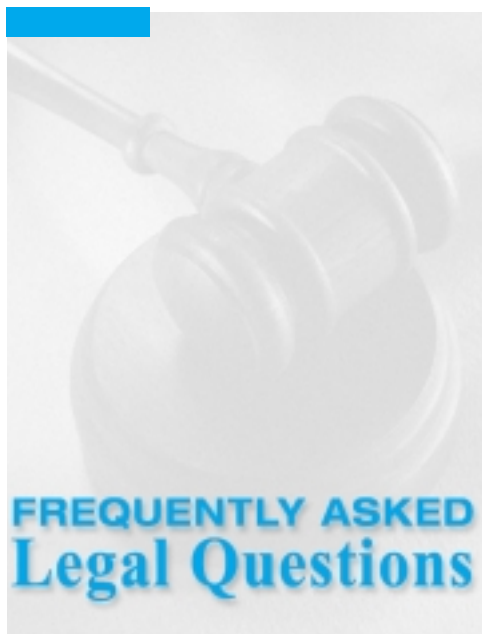
Consider the case entailing a 42 year-old female with history of a herniated disc and depression who experienced a fall injury and re-injured her back. Diagnostic studies indicated a slight disc bulge. Conservative treatment was rendered over a nine month period, however the patient continued to complain of radiating back pain. Additional radiographic studies revealed negligible findings. The patient was then evaluated by an anesthesiologist who recommended that an epidural block be performed. Caudal and epidural blocks were subsequently performed. Immediately following the blocks, the patient experienced loss of bowel and bladder control. Further diagnostic studies led to a diagnosis of cauda equina syndrome secondary to the epidural block. Suit was filed against the anesthesiologist alleging lack of informed consent and negligent performance of the epidural block. Unfortunately, the anesthesiologist failed to document the patient's clinical symptomology nor his discussion of the risks and possible complications of the procedure. Medical experts could not support the anesthesiologist's recommendation for the block nor support informed consent in light of the inadequate documentation. Consequently, settlement was necessitated in the amount of \$750,000.



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Q. What action should be taken when a "Notice of Intent" letter is received?

Immediately notify APAC by calling the Claims Department at 866-294-6014. APAC only has a limited number of days to prepare a response on your behalf to the notice of intent and assign a defense attorney, if necessary. It is important to not discuss the case with the patient, the patient's attorney or other parties involved in the care and treatment of the patient. You should gather and secure the patient's records immediately.

Q. Is there a specific number of CRNA's that can be supervised by a Florida physician?

Florida Administrative Code (64B8-35.002) stipulates that the number of persons supervised shall be limited to insure an acceptable standard of medical care is rendered. Factors to be considered in determining the number supervised include patient risk, education level of the CRNA, complexity and risk of the procedure(s), practice setting and the availability of the physician. Additionally, a written protocol, signed by all of the parties, must be in place which describes the individuals covered by the agreement, the duties of the parties covered (Physician and CRNA), the areas of responsibility of the CRNA, an annual review policy and a list of the specific conditions requiring direct evaluation or consultation by the physician. The protocol must be filed annually with the Department of Health. For underwriting purposes, APAC limits the number of CRNA's that may be supervised to a maximum of four.

Q. What is arbitration and what benefit does it provide?

Arbitration is the submission of a dispute to one or more impartial persons for a final and binding decision. Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party. It is also believed that arbitration panels will help to avoid unreasonable jury awards, thereby further lowering costs. These cost savings would positively impact professional liability rates and the cost and availability

of healthcare services.

Q. What is the statute of limitations for medical malpractice?

IN FLORIDA: Two years from the date of the incident giving rise to the action or two years from the time that the incident caused by medical negligence is discovered or should have been discovered, but in no event later than four years from the date of the negligent incident or occurrence. However, the four-year period of repose will not bar an action brought on behalf of a minor on or before the child's 8th birthday. If it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of injury, the period of limitations is extended to seven years from the date the incident giving rise to the injury occurred. This seven-year period does not bar an action on behalf of a minor if made on or before the child's 8th birthday.

Q. Do HIPAA Privacy Rules prevent a physician from discussing a patient's health status, treatment, or payment arrangements with the patient's family and friends?

No. Not, if the information discussed is relevant to the care and treatment of the patient and the patient does not object to the discussion. For example, a physician may discuss the patient's physical limitations to a relative caregiver; to a family member for instructions on medication dosage; or to a friend who may be providing transportation to the patient.