

Preventive Action

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Pre-operative Loss Prevention Strategies

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The pre-operative period provides a two-fold opportunity for proactive loss prevention. First and foremost, it is the time to single out clinical co-morbidities, as well as mechanical inadequacies; and to subsequently, enable the physician to make informed decisions to enhance patient safety. Secondly, it is the chance to develop a relationship of trust and confidence between the anesthesiologist and the patient.

Pre-anesthesia Evaluation & Interview

While most patients are asked to complete a self-assessment questionnaire, problems occur when it is incomplete, or not reviewed prior to the procedure. A second risk exposure occurs when the pre-operative history and physical is too brief. A prevalent exposure for the anesthesiologist is related to airway management. The recent ASA Closed

Claims Project finds that difficult intubation is the second most frequent initial event leading to anesthesia medical malpractice claims.

The study concludes that a significant proportion of claims regarding difficult airway management had no preoperative assessment. A preoperative airway history was not conducted in 25 percent of the claims.

Strategy

1. Review the self-assessment questionnaire with the patient.
2. Ensure that the history and physical facilitates optimum anesthesia management.
3. Perform and document a preoperative airway history to include:
 - Prior airway difficulty
 - Congenital or acquired coexisting disease
 - Prior surgical procedures and anesthetics

Physical Examination

Referring to the ASA Closed Claims Project, a physical examination was not done prior to anesthesia in 22 percent of the claims involving a difficult airway.

Strategy

1. Appropriate physical assessment should address all major systems, to be pertinently repeated immediately before induction.
2. Document the airway assessment, any physical abnormalities which would impact patient positioning or require special attention, and the

patient's ability to cooperate and communicate effectively.

3. Ensure that the operating room is arranged with all necessary equipment, supportive pads, and positioning aides before the patient enters.

Pre-surgical Workup, Laboratory/Screening Tests

While appropriate guidelines for pre-surgical workup are usually followed, there is an exposure if the results are



not reviewed before anesthesia and surgery.

Strategy

1. Ensure that diagnostic reports, consultations, and medical clearances are on the chart pre-operatively.
2. Indicate special precautions, techniques, monitors, or other mechanisms in place predicated upon the pre-existing condition of the patient.

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Anesthesia/Monitoring Equipment

Claims associated with gas delivery equipment are infrequent but severe. In a claims analysis of adverse anesthetic outcomes, 2 percent were related to anesthesia equipment, however, most of these problems (76 percent) resulted in death or brain damage. Misuse of equipment was more common than equipment failure. [1]

Approximately one-third of the negative outcomes could have been prevented by use of additional monitors. The adverse outcomes judged preventable by additional monitoring (end tidal CO2 and pulse oximetry) are eleven times more costly than those mishaps not deemed preventable.[2]

“...the payment range was considerably higher in the claims with inadequate informed consent.”

Strategy

1. Ensure that well maintained and appropriate equipment is available to include all standard monitoring devices.
2. In-service staff on new equipment before it is used.
3. Prevent insufficient inventory by not sharing equipment.
4. Validate the systems/equipment check, before each case, on the anesthesia record.

Informed Consent

A claims analysis, in which informed consent was an issue, reveals that the liability profile of claims involving inadequate informed consent was less favorable overall than the profile of claims in which informed consent was considered adequate. Payment to the plaintiff was made in 73 percent of the claims associated with inadequate informed consent as opposed to 40 percent of those with adequate consent. Moreover, the payment range was considerably higher in the claims with inadequate informed consent. No claims among those with adequate informed consent resulted in payments of more than \$500,000 as compared to four claims with payments of \$1 million or more in the claims with inadequate informed consent. [3]

Inadequate informed consent is characterized by defects in the process as well as in documentation. Inadequate communication of the risks, benefits, and alternatives of anesthesia have led to patients' alleging that they were not informed of the possibility of complications, such as infection at the epidural site, or headache after spinal anesthesia.

“The high frequency and severity factors of anesthesia claims necessitate appropriately applied loss prevention strategies.”

Strategy

1. List and discuss the specific risks and benefits of the planned anesthesia
2. List and discuss co-morbidities, which impact the risks of anesthesia.

HIPAA

PRIVACY RULE: DISCLOSING A PATIENT'S PHI TO FAMILY MEMBERS

Under HIPAA privacy rules, a physician may contact disclose a patient's protected health information (PHI) when attempting to reach family members regarding a patient's location, condition, or death.

According to the HHS Office of Civil Rights, the patient's written authorization is not required when sharing health information to notify, identify, or locate a patient's family members or other persons responsible for the patient's care.

If the patient is present and has the capacity to make health care decisions, the doctor or hospital may disclose PHI for notification purposes if the patient does not object. Disclosures are also allowed if it can be "reasonably inferred" from the circumstances that the patient would not object.

When the patient is not present or is incapacitated, a physician can still disclose a patient's location, general condition, or death when attempting to notify family, as long as the disclosure is deemed by the doctor to be in the patient's "best interest."

A physician is permitted to share information about a patient's condition:

- In order to provide emergency communications with members of the U.S. military, via the American Red Cross, such as informing service members of family illness or death, and verifying such illnesses for emergency leave requests.
- When needed by police to help locate and communicate with the family of an individual killed or injured in an accident.
- When contact with a patient's employer is necessary to assist in locating the patient's spouse so that he/she may be alerted to the hospitalization of the patient.

3. Obtain the signature at the conclusion of the discussion between the patient and the provider, once all questions have been resolved.

The high frequency and severity factors of anesthesia claims

necessitate appropriately applied loss prevention strategies. Seek legal or risk management guidance at the first indication of a situation that could develop into malpractice litigation. This often enhances your defensibility.

[1] Caplan RA, Vistica MF, Posner KL, Cheney FW: Adverse Anesthetic Outcomes Arising from Gas Delivery Equipment: A Closed Claims Analysis. *Anesthesiology* 87: 741-8, 1997.[2] Tinker JH, Dull DL, Caplan RA, Ward RJ, Cheney FW: Role of monitoring devices in prevention of anesthetic mishaps: A closed claims analysis. *Anesthesiology* 71:541-546,1989.[3] Caplan RA, Posner KL: Informed consent in anesthesia liability: Evidence from the Closed Claims Project. *ASA Newsletter* 59(6): 9-12, 1995.

Pain Management Claims

OBJECTIVE

Implementation of loss prevention measures designed to reduce claim frequency and severity attributed to pain management.

CONCLUSION

Claims related to the management of chronic pain have risen significantly - from 6 percent of APAC's total claim volume 10 years ago to over 20 percent. A significant root cause of the claim increase is attributed to doctors exceeding the limits of their competency.

DISCUSSION

A claim study entailing pain management released by the Physician Insurers Association of America (PIAA) in 2002 revealed that half of claims were for anesthesiologists. Most frequently, improper performance was the misadventure cited, and of these, over 43 percent resulted in an indemnity paid to the claimant with an average payment of \$249,000. APAC underwriting guidelines differentiates pain management procedures that should be performed only by those anesthesiologists with specialized expertise.

1. Procedures that can be performed by any anesthesiologist who has completed an approved residency in anesthesiology	2. Procedures that should only be performed by anesthesiologists certified in pain management by the American Board of Pain Medicine	3. Procedures that should only be performed by anesthesiologists approved for category 2 procedures who have experience in doing these procedures. If these procedures are new to them, they must be proctored by an appropriate mentor for 5 cases to qualify for coverage
<ul style="list-style-type: none"> ■ Peripheral nerve blocks ■ Superficial head and neck blocks ■ Paravertebral injections ■ Spinal and epidural injections 	<ul style="list-style-type: none"> ■ Deep head and neck blocks (sphenopalatine ganglion) ■ Coeliac plexus blocks ■ Lumbar discography ■ Neuroablative procedures <ul style="list-style-type: none"> ▫ Cryo ▫ Radiofrequency ▫ Chemical 	<ul style="list-style-type: none"> ■ Spinal stimulator implantation ■ Pump implantation for spinal and epidural narcotics ■ Epiduroscopy ■ Cervical and thoracic discography ■ Percutaneous disk therapies <ul style="list-style-type: none"> ▫ IDET ▫ Laser

FLUOROSCOPY SHOULD BE UTILIZED FOR ALL CATEGORY 2 AND CATEGORY 3 PROCEDURES

Rx LOSS PREVENTION

Consider the case entailing a 40 year-old married female referred to our insured pain management specialist, suffering from chronic low back pain and depression. The patient had been treated over the years with numerous anti-inflammatories, pain medications and anti-depressants. The Insured treated the patient for her low back pain, electing to remove the patient from all pain medications and place her on Methadone. The patient was specifically told to discontinue all pain medications, however, Elavil was not mentioned by name since it was the insured's understanding that the patient was taking the Elavil for pain. However, because the patient was taking the Elavil for her depression, she continued to take it along with the Methadone and subsequently suffered an overdose resulting in cardiac arrest and death. A wrongful death suit was brought against our insured for failing to monitor all of the patient's medications, specifically, failing to discontinue the Elavil. Defense experts could not support the case in light of the insured's failure to clarify the patient's medication history and use. Consequently, the claim necessitated settlement in the amount of \$375,500.





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How long must a physician retain medical records?

Per Florida Administrative Code 61F6-26, for five years. However, APAC recommends that records be kept for a seven-year period from the point of last patient contact given the maximum statute of limitations for medical malpractice. However, for patients under the age of one, records should be retained until the child's eighth birthday. If the patient is age one year or older, then keep records for the seven year period.

What action should be taken when a medical error is suspected or occurs?

Contact APAC's Risk Management Department for guidance as soon as possible. Make no admissions of liability. Federal and/or state

reporting requirements under strict time constraints may apply. Always attempt to discuss the situation with personal counsel or APAC before meeting with hospital risk management.

Should professional fees be waived or refunded when a patient is dissatisfied?

Not always. It depends on the particular situation. First give the patient the opportunity to describe the reason for their dissatisfaction. Attempt to correct the situation, if possible. If the patient demands a refund, waiver of fees, or the issue cannot be remedied, contact APAC's Risk Management Department or personal counsel for specific guidance. What some may interpret as an act of accommodation, others may view as an admission of liability.

May records be furnished to an HMO/MCO without an authorization from the patient?

No. However, most HMO/MCO providers require such authorization as a condition of coverage. Therefore, the HMO/MCO should be asked to furnish a copy, evidencing the patient's authorization.

What action should be taken when a summons and complaint is received?

Immediately notify APAC by calling the Claims Department at (866) 294-6014. If you are served, APAC only has limited a limited number of days to assign a defense attorney

and prepare a response to be filed on your behalf. 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.

What is a deposition?

A deposition is testimony given under oath before a court reporter. Depositions are important in the preparation of a case for trial. Depositions also freeze testimony and can be used to impeach your credibility if you deviate from them later. They are used to discover facts of the case and to uncover additional witnesses. Depositions are also used to narrow the issues of the case. Failing to appear for a deposition subjects you to the potential to be held in contempt of court.

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.