

Preventive Action

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NEW BLIPS ON THE RADAR SCREEN: ANESTHESIA LIABILITY

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To the credit of diligent and conscientious anesthesia providers, a dramatic and welcome decrease in anesthesia deaths and brain damage is acknowledged by several formidable sources. Among those are the joint commission on health care organization which sites fewer reportable incidents of previous injuries associated with anesthesia such as intubation, aspiration, and nerve injury events which have resulted in death or serious neurological injuries. Diligent loss prevention measures and conscientious application of risk management recommendations have enhanced the quality of care possible with the advent and consistent

use of new technology. The new monitoring technology coupled with this diligence is reducing the trends in death and brain damage by lessening the respiratory and cardiovascular events that made up the majority of sentinel events most frequently reported. Anesthesia malpractice lawsuits have seen a decline in both frequency and severity.

While the decrease in previous adversities is gratifying, there emerge on the horizon new concerns, perhaps partially brought on by changes in the healthcare delivery systems, more frequent use of new technology, and the changing venue of office-based and outpatient surgery. Recent concerns include injuries and subsequent litigation arising from pain management and office-based anesthesia services; injuries sustained due to central catheterization and cautery fires; and visual losses attributed to intra-operative anesthesia care. Obviously, the new issues warrant the same attention and proactive response as did the former.

- Injuries resulting from pain management procedures are increasing, as are claims, and the

resulting indemnity payments. The most common injuries cited include nerve damage, pneumothorax, headache, and back pain. The injuries are reported from both chronic pain management and surgical/obstetric acute pain management services. The most prevalent exposures include those associated with improper treatment or failure to adhere to recommended treatment guidelines, misdiagnosis, the non-compliant patient, narcotic abuse, violent behavior, and allegations of abandonment. Recommended loss prevention strategies include subscribing to JCAHO's new standards for pain management. Document all patient contacts including the treatment rationale. Perform a thorough H & P, to include the diagnostics and referrals necessary to rule out serious medical conditions. Ensure the patient meets criteria prior to treatment. Negotiate a comprehensive informed consent. Confirm an adult chaperone before treatment. Document non-compliance, and provide security against violence towards staff and other patients.

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Anesthesiologists Professional Assurance Company



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For comments, questions or to obtain additional copies contact the Anesthesiologists Professional Assurance Company Risk Management department at 866-294-6014, ext. 3016.

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- Office-based anesthesia claims have a higher severity of injury with a higher percentage paid and a higher indemnity paid out. A greater proportion of these claims could be preventable by more careful monitoring of patients. It is recommended to focus on patient selection, limited surgical procedures, and providing adequate post-operative recovery period with appropriate professional staff and monitoring and resuscitation equipment and staff training. Clear and concise documentation is necessary for continuity of care as well as validation of the quality of care.
- The proportion of claims or injuries related to vascular access or catheter placement has risen steadily over recent years. Most frequent types of central line complications include hemothorax, carotid artery injury, cardiac tamponade, pneumothorax, and embolism. Half of central catheter claims have been judged as being preventable by ultrasound guidance, pressure waveform monitoring, or chest radiograph.
- Unfortunately, patients die each year in operating room fires. The causes of burns in the OR are frequently due to cautery or laser fires associated with airway surgeries. Skin burns are due to use of IV bags for warmth and pooling of prep solutions under the patient. Unregulated warming devices are also attributed to recent serious burns. Loss prevention recommendations include encouraging the use of sharp dissection when opening the trachea and holstering the Bovie when not in use. Be alert to the source of ignition during supplemental oxygen use. The laser should be on stand-by when not in use. Discourage flammable prep solutions and ensure that these do not pool under the patient. Avoid the use of heated IV bags for patient warmth.
- Post-operative visual loss is rare and the causes are poorly understood. The concern is evidenced by the Visual Loss Registry established by the American Society of Anesthesia Committee on Professional Liability. This committee addresses post-operative visual loss that does not involve ocular surgery. Peri-operative visual loss is most frequently associated with prone spine surgery. The risk factors include the length of the surgical time, the presence of anemia or excess blood loss, and hypotension. Recommendations include avoiding external pressure on the eyes, avoiding anemia, maintaining adequate venous pressure, meticulous documentation, and a detailed informed consent.

Given the successful reduction in the previous injuries and claims attributed to anesthesia services in the past, it is anticipated that consideration of these new risks will spark a due diligence to deploy the recommendations intended to enhance patient safety and reduce the likelihood of medical malpractice claims.

References: ASA Committee on Professional Liability, *Current Trends in Liability Physicians Insurers Association of America, Closed Claim Data First Professionals Insurance Company, Comprehensive Risk Management for Surgical and Anesthesia Services.* —

APAC Risk Management Bulletin

SUBJECT

Dealing with Adverse Outcomes

OBJECTIVE

Implementation of loss prevention measures designed to reduce claim frequency and severity attributed to adverse outcomes.

CONCLUSION

Bad things can happen to good doctors. How they are dealt with and handled can have a significant impact on their resolution.

DISCUSSION

Medical malpractice claims are usually the result of an adverse event or outcome arising out of a medical procedure or course of treatment. The actions that are taken immediately after an event of this type occurs are extremely important to its successful resolution. When an adverse event occurs, it should be reported promptly to your insurance carrier. The incident should also be reported to the hospital's risk management department. This is the best time to write down your entire recollection of the events while they are still fresh in your mind. This documentation should be kept in a secure place where it can be retrieved in the future. Additionally, preserve any other evidence that might be pertinent to the event, including medications and equipment that may have malfunctioned. Under no circumstances should you attempt to "cover up" the incident either in the written records or in discussions with the family. Hiding a problem can lead to punitive actions being brought against you. Most importantly, do not attempt to conceal your liability or any facts of the incident by altering (or falsifying) any of the medical records.

The following actions are recommended when an adverse outcome occurs:

- Accompany the surgeon to deliver the news to family members
- Express your sympathy in a caring and empathetic manner
- Do not profess any guilt or innocence
- Where possible, provide the family with an explanation of what transpired
- Assure the family that everything possible was done for the patient

The maintenance of a good relationship with the family is crucial. Studies have shown that even the tone of voice and the manner in which bad news is delivered will directly affect the actions that the family will take. —

What Physicians Need To Know About The "Red Flags" Rule

The Federal Trade Commission (FTC) has issued rules that require "financial institutions" and "creditors" holding consumer or other "covered" accounts to develop and implement an identity theft prevention program. Enforcement of these rules, referred to as the "Red Flags" Rule (Rule), is effective August 1, 2009.

The Rule affects individual physicians, physician groups, hospitals and other health care organizations that qualify as a "creditor", which is defined as "any person who regularly extends, renews, or continues credit" or "defers payment of a debt." Health care practitioners routinely extend "credit" by performing services and "billing" the patient at a later date either through sending a claim to the insurance company and/or accepting partial payment or co-pays and thus have been interpreted to be a "creditor" by the FTC under the Rule.

Anesthesiologists Professional Assurance Company (APAC) has developed a packet of material to help clarify the Rule

pertaining to patient identity theft protection standards. The packet contains an overview of the new Rule, risk management guidelines, and web site references. It also contains several forms and templates to assist with compliance measures.

Due to the relative depth of the Rule, APAC suggests that all policyholders establish a reference manual for their offices, ideally as an addendum to current HIPAA reference material. This packet, along with any other additional materials obtained, will be a vital resource in implementing protection against patient identity theft and compliance with the Rule.

For policyholders of APAC, the complete Rule package, including compliance measures, is available within the risk management link on our web site, www.apacinsurance.com. If you have any questions about this material or require additional copies, contact APAC's risk management department at (800) 741-3742, extension 3016 or send an e-mail to rm@fpic.com. —



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Legal FAQs For information specific to your state of practice, contact APAC's Risk Management department



What is meant by the legal term 'discovery'?

In trial practice, the pre-trial devices that are used by one party to obtain information about the case from the other party in order to assist the party's preparation for trial. Tools of discovery include depositions, written interrogatories, production of documents including medical records and personal records, physical and mental examination, and requests for admission.

What is meant by a 'root cause analysis'?

A widely adopted method of identifying underlying causes of medical error.

An effective RCA looks beyond the immediate result and identified the chain of events or contributing factors which led to the error.

What does the term 'respondent superior' mean?

Respondent superior is a legal doctrine, translated as "let the master answer". In medical malpractice actions, the doctrine is invoked when a physician is being held liable for the acts of a non-physician whose actions the physician controls, or has the right to control. Depending on the situation, the right to control need not have been exercised to permit invoking the doctrine.

What is the definition of 'proximate cause'?

An act or omission that naturally and directly produces a consequence. It is the superficial or obvious cause for an occurrence. Treating only the "symptoms," or the proximate special cause, may lead to some short-term improvements, but will not prevent the variation from recurring.

What is an 'adverse drug event'?

Any incident in which the use of a medication (drug or biologic) at any dose, a medical device, or a special nutritional product (for example, dietary supplement, infant formula, medical food) may have resulted in an adverse outcome in a patient.

Pursuant to Universal Protocols, does the surgical site need to be marked for all procedures or is it just for right/left procedures?

Marking the site is required for procedures involving right/left distinction, multiple structures (such as fingers and toes), or levels (as in spinal procedures). Site marking is not required (nor is it prohibited) for other procedures. These may include mid-line sternotomy, Cesarean section, laparotomy and laparoscopy, cardiac catheterization and other interventional procedures for which the site of insertion is not predetermined. For those procedures in which site marking is not required, the other requirements for preventing wrong site, wrong procedure, wrong person surgery still apply. —