

Preventive Action

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Anesthesiology Loss Trends

By Cliff Rapp, Vice President, Risk Management

One of the best malpractice claim data sources is the Physician Insurers Association of America (PIAA). Since 1985, PIAA has collected data on over 200,000 medical malpractice claims. These data include information on over 7,743 claims against anesthesiologists. Examining loss trends serves as a benchmark for loss experience, helps to determine risk exposure, and facilitates effective loss prevention measures necessary to reduce the frequency and severity of malpractice claims.

Although the frequency factor of malpractice claims against

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Anesthesiology Claims by Misadventure

	Average Severity	Payment Rate	Average Indemnity
No Medical Misadventure	5.5	6.3%	\$163,961
Improper Performance	5.2	32%	\$166,278
Intubation Problems	5.6	48%	\$244,601
Problems w/ Patient Monitoring in Surgery	6.1	46%	\$315,675
Error In Agent Use	5.5	39%	\$257,050

anesthesiologists has remained relatively stable, the spiraling increase in claim severity is disturbing. In 1985, the average indemnity payment on behalf of anesthesiologists was \$93,537. That figure rose to \$403,095 in 2004.⁽¹⁾ Closed claim data also reveals an increase in the number of claims with higher injury severity such as death, a grave condition, and major permanent injury. Perhaps the most troublesome trend is the increase in the percentage of claims that were settled in 2004 with an indemnity payment. There has also been an increase in the number of office-based procedures. These office-based claims have multiple concerns because, on average, they have a higher severity of injury and higher proportion and amount of payment.⁽²⁾

In analyzing PIAA closed claim data, it is surprising that the most common

type of misadventure for claims involving anesthesiologists is “no medical misadventure” – those claims in which there is an absence of medical error. Frequently, these claims entail legal issues such as informed consent and the anesthesiologist’s vicarious liability for another. While these claims have a low payment ratio of 6.3 percent and a relatively low average indemnity of \$163,961, they are the most expensive misadventures to defend. In terms of misadventure, the highest average severity (major permanent issue) was “problems with patient monitoring in recovery”, with a payment ratio of 40 percent and an average indemnity of \$341,784. Although claims involving “problems with patient monitoring in surgery” have a slightly lower average

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indemnity, payment is made in almost one half of these claims.

The medical condition that results in the most claims against anesthesiologists is back disorders. This condition has an average indemnity payment of \$261,521 and a payment ratio of 25 percent. The spiraling increase in pain management services is one factor for the increased frequency of claims. However, the condition that has the highest average indemnity payment as well as the highest injury severity, is that of a brain damaged infant. Claims involving this type of condition have an average indemnity of \$488,544 and are also the most expensive to defend.

Case Synopsis

A 42-year-old female with history of surgery for a herniated disc and depression, fell and re-injured her back. Diagnostic studies indicated a slight disc bulge. Despite conservative treatment over a nine month period, the patient complained of radiating back pain. Additional radiographic studies were conducted with negligible findings. The patient was referred for pain management to the insured anesthesiologist who recommended and performed caudal and epidural blocks. Immediately following the procedure, the patient experienced loss of bowel and bladder control. Further diagnostic tests revealed cauda equina syndrome secondary to the epidural block. The patient filed suit against the anesthesiologist, alleging lack of informed consent and negligence in performing the procedure. The patient was not required to sign an informed consent form, nor was there documentation made of any discussion with the patient regarding the side effects and possible complications of the procedure. Medical experts could not support the anesthesiologist's decision to recommend the block nor the issue of informed consent. Consequently, settlement was necessitated in the amount of \$750,000.

In terms of loss location, the operating room is where the majority of patient injury occurs. The PIAA closed claim data reveals that 73 percent of claims against anesthesiologists arise from the operating room and that more than a third result in an indemnity payment, on average of \$188,932. However, the emergency room is the location that had the highest average indemnity payment of \$339,701. Although the critical care unit is the location having the highest patient injury severity, claims arising from the CCU result in a lower average indemnity payment than that of other loss locations.

Informed consent continues to remain a problem in defending anesthesiology claims, with a payment ratio of nearly 40 percent. Most claims involving informed consent issues can be prevented with basic risk management practices. Other non-medical, associated issues include the lack of adequate facilities and communication between providers. Although claims involving non-medical issues are expensive and among the most difficult type to defend, they are the easiest to avoid.

Other noteworthy trends in anesthesiology are emerging claims involving pain management, central p catheterization, burn injury, and vision loss - important factors in terms of determining future loss exposure.

Risk Management Recommendations

- Whenever possible adhere to ASA guidelines and recommendations.
- Communicate fully with patients that are unusually anxious or at increased risk for complications.
- Establish rapport with family members of those patients that are unusually ill, or at usually high-risk for complications.
- Obtain informed consent. When necessary, modify standard, written consent forms to include risks and complications specific to the patient. Despite the low claim severity, include a disclaimer for dental injury.
- Document all preoperative evaluations and discussions to support your medical rationale.
- Adhere to the standard of care relating to the choice of agents and techniques.
- Confirm and document the correct position of airway/endotracheal tube placement. Note any problems encountered and all attempts at tube placement.
- Ensure that the same risk management practices are followed by those CRNA's that you supervise.
- Confirm spinal level in conjunction with preoperative records and consent forms. Document with specificity catheter type, insertion and adequacy of line placement.
- Document the patient's condition at time of transport to the Recovery Room.
- Respond promptly when an incident occurs. Obtain necessary consultation and verify that all diagnostic and therapeutic steps have been taken. Failing to do so could subject you to actionable abandonment.
- Increase your communication with the patient or family should a complication arise and document your interactions.
- Seek legal or risk management guidance when necessary.

(1) PIAA Research Notes, Spring 2005

(2) Domino, K. *Current Trends in Anesthesia*. ASA Committee on Professional Liability. 2004

PRACTICE UPDATE: Maintain CME Records for Four Years!

The Florida Department of Health recently announced that following the 2006 licensure renewals, it will greatly increase the number of CME audits it performs.

- Currently 3 percent of licenses are audited. The Department plans to increase the number to 25 percent.
- The Department has up to two years to audit the previous licensure biennium – therefore CME records need to be maintained for at least four years.
- If you fail to demonstrate compliance with the CME requirements, you can be issued a citation and fined up to \$50 per hour.
- If you are unable to demonstrate compliance with the mandatory requirements (HIV/AIDS, Domestic Violence and Medical Errors), you can be fined up to \$500 per course.

Protect yourself from an unnecessary action by the Board of Medicine. Keep your CME records up-to-date.



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FREQUENTLY ASKED Legal Questions

What is meant by the legal term *Res Ipsa Loquitur*?

A latin phrase for “the facts speak for themselves.” *Res ipsa loquitur* is a rule of evidence under which an individual is deemed, under certain specific circumstances, to be negligent by mere occurrence of the incident and where the law presumes that the injury could not have occurred but for negligence. An example of a *res ipsa loquitur* case would be a retained foreign body claim.

Does Florida law set forth the manner in which prescriptions must be written?

Yes. Pursuant to FS 456.42 effective July 1, 2003, all written prescriptions must be legibly printed or typed and must be signed by the prescribing practitioner on the date issued and

must contain the name of prescribing practitioner; name and strength of the drug; quantity of the drug in both textual and numerical formats; directions for use; and the date of the prescription with the month written in textual letters.

How long must a physician retain medical records?

Per Florida Administrative Code 64B8-10.002, for five years. However, APAC recommends that records be kept for at least a seven-year period from the point of last patient contact given the maximum statute of limitations for medical malpractice. 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.

What action should be taken when a patient is noncompliant or refuses to undergo diagnostic studies, care, or treatment?

Document your recommendations and the patient’s noncompliance. Advise the patient of the potential consequences of their noncompliance or refusal and document your discussion. Confirm the patient’s noncompliance, your subsequent discussion and the potential consequences in a letter to the patient sent certified mail, return receipt requested and send a copy of the letter by regular mail as well. Consider withdrawing from the patient’s care, but first review the language of any managed care contracts that may apply to the situation and seek guidance from APAC’s Risk Management Department or personal counsel. If you practice in a group setting, it may be necessary to withdraw on behalf of others in the group and the practice itself.

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 it 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.