

DEFENDING ANESTHESIA CARE

How to Avoid and Handle Litigation

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Malpractice litigation is a fact of life for most anesthesiologists today. The average anesthesiologist is sued approximately every 8 years. Some large groups, however seem to consistently defy the odds – remaining virtually claims-free year after year. This track record occurs in spite of locations in litigious states with unfavorable legal climates. To determine what factors these groups credit for their own success, they were interviewed by risk managers for a medical malpractice carrier. The following are the anesthesiologists' own perceptions on what helps them prevent malpractice claims.

Knowing your patient:

Whenever possible, the physicians perform their own preoperative assessment. They have found that this avoids the potential for important information not being transmitted to another provider, and also helps to establish a physician-patient relationship prior to entering the operating room. Outpatients are telephoned at home the night prior to surgery, which helps build rapport, communicate information about oral medication and NPO status, and identify potential problems in advance. Inpatients are seen in-house the night before surgery.

An outpatient surgery nurse obtains a thorough history when the patient first registers at the hospital. The anesthesiologist can then review this assessment with the patient, along with the surgeon's history and physical, laboratory work and old medical records, which have been placed with the chart. Anesthesiologists are encouraged to review the nurses' notes thoroughly as these entries often contain valuable information the patient did not communicate to the physician, such as extreme anxiety about the procedure. One suggestion is to keep questions to patients very specific. For example rather than asking, "Did you have any problems with anesthesia before?" inquire directly about any problems with nausea and vomiting, pain or postspinal headaches.

Patients are also routinely seen or called postoperatively. Such personal interaction projects concern for the patient and provides the physician with first-hand insight into potential problems or complaints the patient might have regarding the anesthetic. Patients who have been given a chance to ventilate their concerns are also less likely to take their grievances to another level.

Working with Others:

These groups have excellent working relationships with the nursing staff in the preop, OR and recovery areas. They feel that the nurses are caring and competent and will notify the physicians whenever circumstances call for it. The physicians strongly encourage the nurses to call them or another partner whenever they are concerned about a patient. The anesthesiologists provide education to the recovery room nurses on a regular basis on subjects such as new anesthetic techniques.

One group provides a daily “free physician”, who carries a cell phone and pager, and is available for immediate response within a few minutes. This physician is responsible for the recovery room, where events can precipitate rapidly, and also provides backup or assistance to any area of the hospital. When a problem arises in the OR, not only does the “free” person respond, but also any available member of the group is expected to come and see if help is needed. As many as 6 anesthesiologists may be working on a single emergency. As the group leader states, “we simply manpower problems to death”.

The anesthesiologists feel that it is essential to be comfortable with the other physicians with whom they interact. Professional disagreements regarding patient care are unavoidable, but group members make an effort to always keep the focus on patient safety, to stay calm and professional, and to avoid having “winners and losers” in interactions with surgeons. Anesthesiologists are encouraged to participate in hospital committees and to attend all group meetings. As one anesthesiologist put it, “Be accountable to your practice with a focus that your provision of services impacts everyone in the group, not just you.”

Good Group Dynamics:

The group members are all partners or on partnership tracks. The ownership component helps ensure that physicians feel responsible for how the group is perceived and how their individual performance affects that. One group did try employing other physicians on a locum tenens basis, but found that those physicians, although competent, were more focused on individual day-to-day events rather than the overall picture and were less likely to go the extra mile or do extra work when needed. Group members readily support each other for bathroom and lunch breaks, and work together to cover late cases if someone has to leave. If issues come up regarding compensation inequities, they are promptly discussed with the entire group. They want all members to feel fairly treated and part of the team.

Both group allows members to specialize in areas like obstetrics, cardiac or neurosurgical anesthesia. They feel this allows development of a strong skill set and enhances rapport with a small group of surgeons. They also feel this enhances accountability for ensuring the smooth functioning of their particular “unit”.

New members are selected based on extensive experience and expertise. Both groups have rigorous selection procedures in place. The applicant must have a good record, and references are obtained – not only standard peer references, but also nurses and surgeons with whom the applicant has worked. Even with such high scrutiny, the group still regards new anesthesiologists as being on probation for one year, during which time they are repeatedly reviewed. After one year, they are re-evaluated and if all group members agree, they move into a partial partnership slot and are observed for another year.

Quality Assurance:

Every physician in the group takes part in formal quality assurance committee activities, which keeps them up to date on current issues. With all physicians participating in medical records reviews, they are more aware of the importance of good documentation. The spirit is one of helping each other look at things from a different perspective. They all accept and understand this process so that it doesn’t degenerate into “one-upmanship”. All anesthesiologists are encouraged to be proactive in developing new methods to ensure safe patient care and avoid complications.

Group members also participate in hospital or surgery center committees. It keeps them up to date on new developments and enhances rapport with other physicians. The groups commented on the excellence of the credentialing process for the other hospital physicians as well. As a result, the surgeons and Ob/Gyn's with whom they work have also been carefully selected. Anesthesia equipment is described as "state of the art" and routine maintenance is continually assured.

Both groups emphasize the importance of the informed consent process. One uses written consents both for the anesthetic and any invasive procedures that are also planned, with copies going to the patient. Patients are thoroughly educated regarding the planned anesthetic and what alternatives there might be should that not prove possible. Common side effects as well as complications are discussed. These groups describe themselves as "careful" and "selective" regarding the patients taken to surgery, meaning they are not reluctant to cancel or postpone cases when appropriate.

Risk Management:

Some negative outcomes are unavoidable, but these groups have found that immediate interaction with the patient or family after an event is invaluable in avoiding claims. For example, with known dental injuries, they don't wait for the patients to complain, they approach them immediately. Without promising any payment or reimbursement, the anesthesiologists tell the patients they are more than willing to work with them to resolve the problem. For small repairs, the anesthesiologists may simply pay for it themselves. If extensive, it is reported to the insurance company as a potential claim. For other bad outcomes, the group always follows up as soon as possible with the patient or family and keeps the lines of communication open.

When an error occurs, everyone in the group is informed. All group members are encouraged to report any unusual events immediately. They then all work on the problem collectively to assure the best possible outcome. All suspected errors go through the formal peer review process. Interestingly both groups have members who perform expert witness services for malpractice litigation. When completed, they use these case studies as learning lessons for the entire group so they can avoid making the same mistakes in their own institutions.

If you are sued:

Despite the best attempts at malpractice risk prevention, it is still possible to be sued. There are no techniques that can guarantee this will never occur. It is important to remember that being sued is a fact of life for most doctors with busy practices and does not represent a personal failure.

Much has been written about the stress on a physician of being named in a malpractice lawsuit. Anesthesiologists may be particularly vulnerable in this circumstance since they do not have a consistent and loyal patient base, and have only transient relationships with the other physicians with whom they work. Often it seems like you are only as good as your last case. Compounding the problem, the operating room is a small environment where bad news spreads rapidly, and the latest anesthetic misadventure may be fodder for locker room and lunchtime discussion for some time. The legal admonition not to speak to other physicians about the details of cases facing possible litigation can leave an anesthesiologist feeling isolated and alone.

All physicians tend to dwell on the facts of cases with adverse outcomes. In retrospect, it can be frustrating how the simple the steps to have avoided the complication will seem. In our specialty, any one anesthetic can be acceptably accomplished in many different ways, so there will always be a number of alternatives to whatever choices were actually made. The standard of care does not depend on 20/20 hindsight, but rather on what a similarly trained physician might have chosen to do under the same circumstances.

Ultimately, we are all human. Errors in judgment or technique will be made, and sometimes patients will have ill effects we wish could have been avoided. Anesthesia is certainly not risk free in the best of hands, and complications will arise in every one of our practices. As those of us who have lived through malpractice litigation can attest, your life and practice will go on. Operating room conversation will ultimately shift to some other more recent or more interesting problem. In the meantime, rather than mulling over what you may have done wrong, try focusing on the positive steps you can take to improve the defense of your malpractice case.

- ❖ Write a detailed narrative of the facts as they occurred. Familiarize yourself with the medical record if available. This will enable you to explain relevant issues to your defense attorney and claims representative.
- ❖ Research topics relevant to your case in anesthesiology texts and in literature available through medical search engines like Medline. This can help your attorney establish the standard of care and identify noted experts. It can also help avoid being surprised by information discovered by the plaintiffs.
- ❖ From a risk management standpoint, ask yourself honestly if your own practices should change to avoid your having a similar complication in the future. Changing your practice after an untoward event, in no way implies that what you previously did was substandard.
- ❖ Spend time on other activities in your life that you enjoy and remember that overwork and sleep deprivation can have negative consequences on your mental state and job function. At work, concentrate on doing your best, not in being perfect. Sometimes doing things a bit more “by the book” instead of cutting corners can help alleviate the unease that another lawsuit is lurking around every corner.

While some physicians seem able to view malpractice claims as simply the cost of doing business, many physicians initially describe feelings of depression or shame after serious complications occur or after receiving notification of an impending malpractice action. Although at first it may seem like things will only get worse, physicians who have been through the entire litigation process will vouch for the fact that life does return to normal. Remember: this too shall pass!

References:

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