ANESTHESIA PROFESSIONAL LIABILITY:
RECENT LIABILITY TRENDS & RISK MANAGEMENT

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CONFLICT OF INTEREST DISCLOSURE

Tracey Dujakovich, JD is a Lead Claims Professional and Risk Advisor for Preferred Physicians Medical, the nation's only provider of medical professional liability insurance exclusively for anesthesia professionals and their practices. The speaker has no additional financial relationships with a commercial interest to disclose nor any undisclosed conflicts of interest.

OBJECTIVES

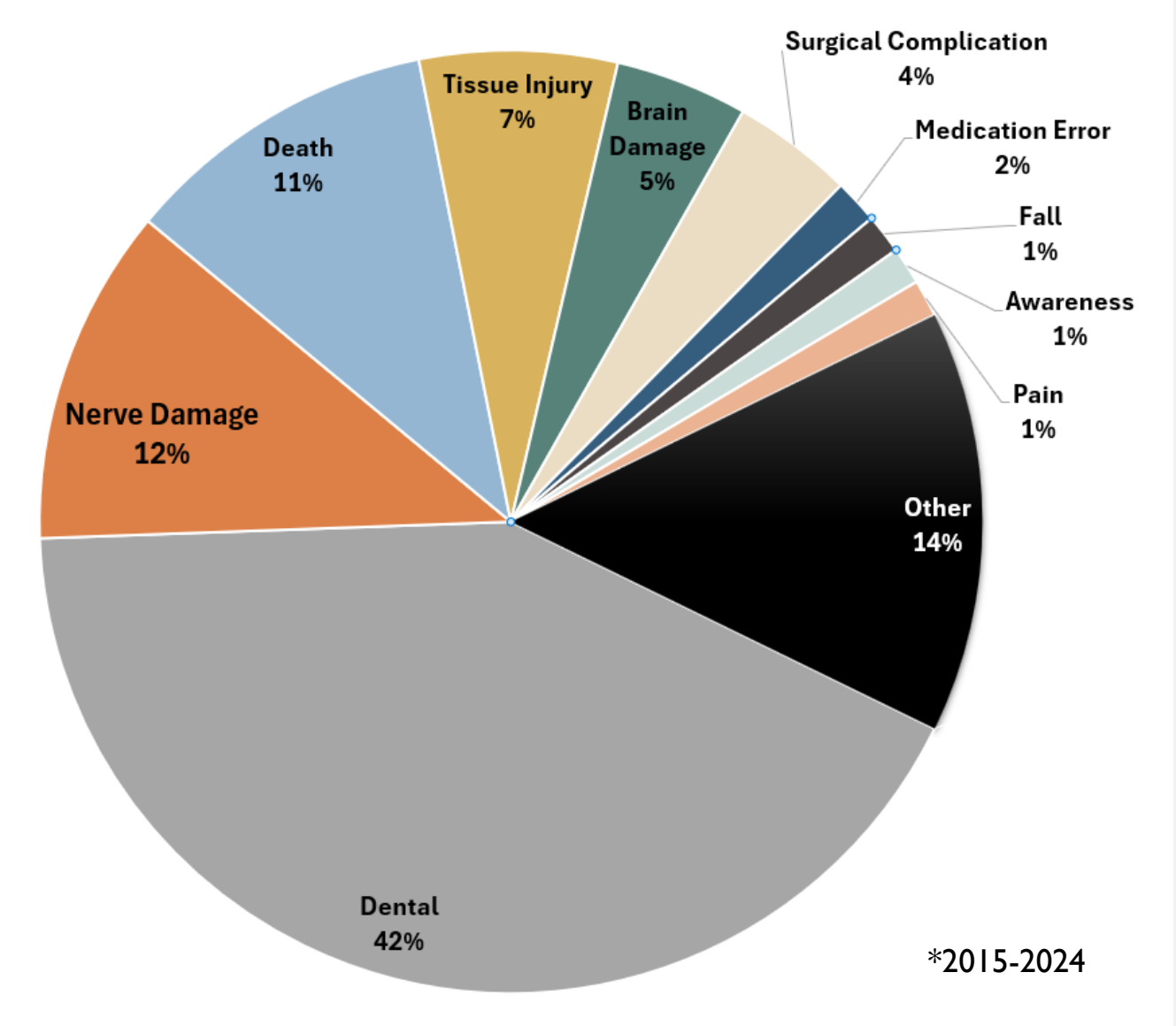
(1) *Have a better understanding of the most common types of claims and lawsuits involving anesthesia professionals.*

(2) *Be able to evaluate potential areas of liability exposure in their own practice.*

(3) *Learn strategies to advance patient safety and mitigate professional liability exposure.*

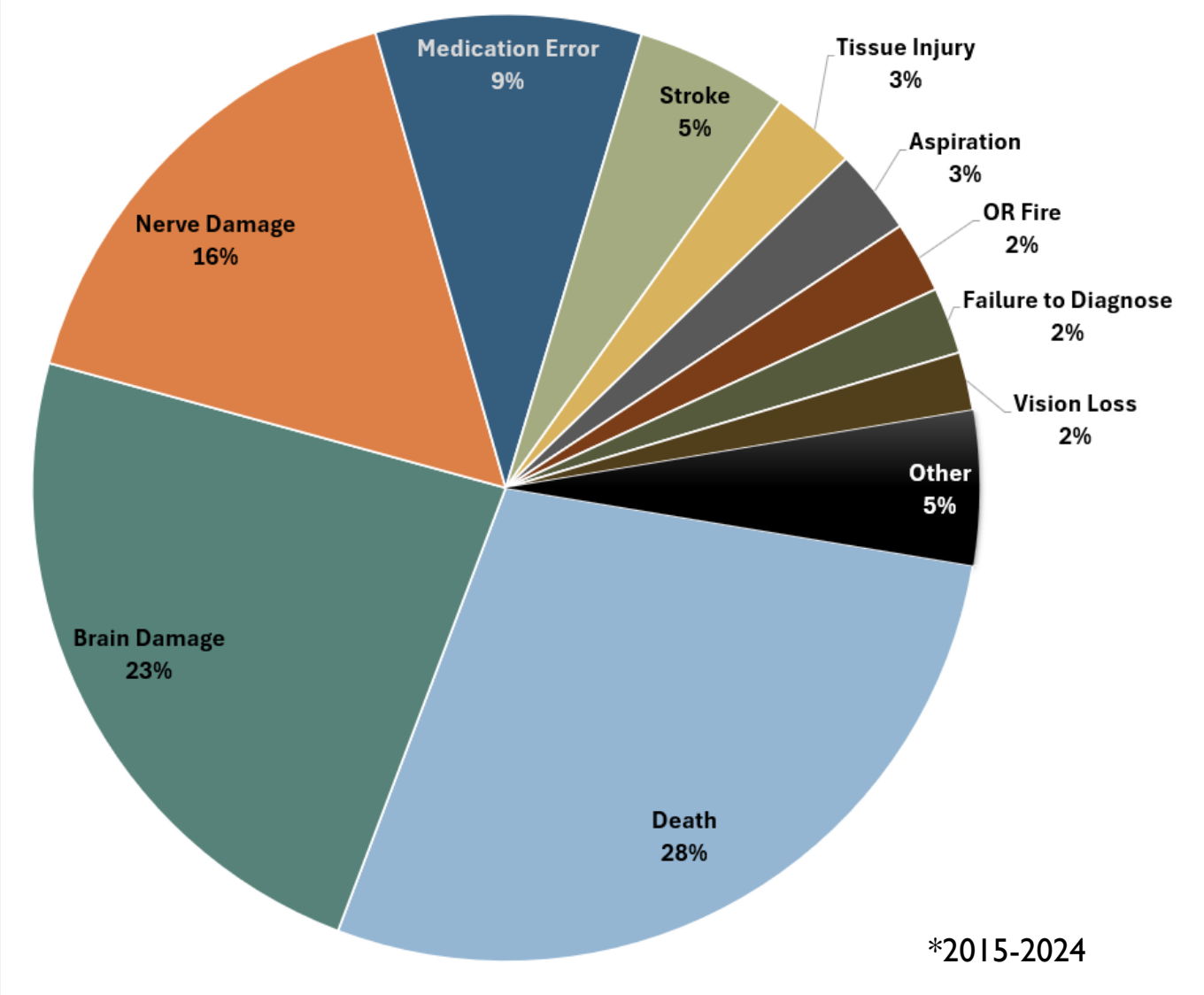
TOP 10 ANESTHESIA CLAIMS – FREQUENCY

1	Dental
2	Nerve Damage
3	Death
4	Tissue Injury
5	Brain Damage
6	Surgical Complication
7	Medication Error
8	Fall
9	Awareness
10	Pain



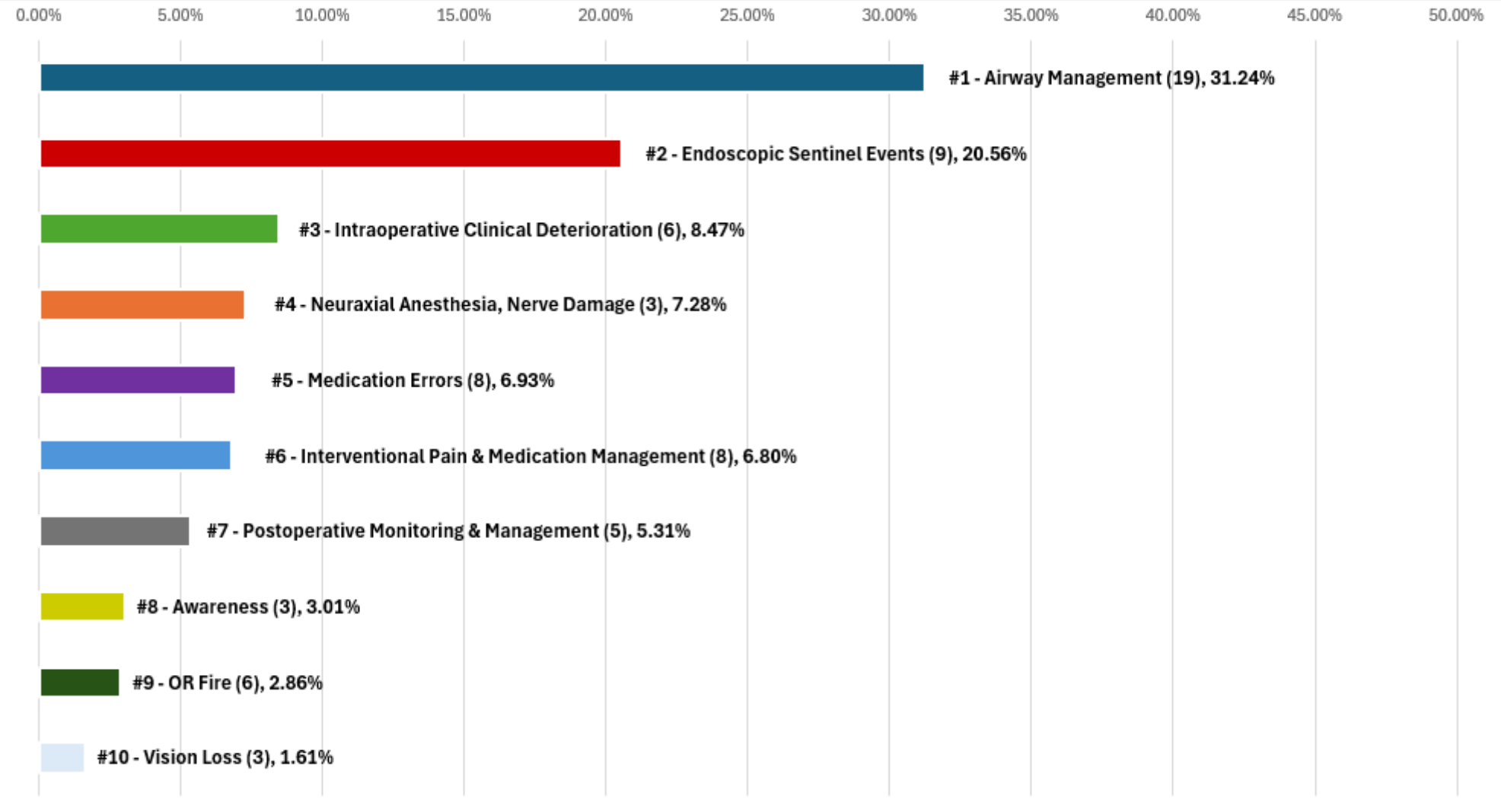
TOP 10 ANESTHESIA CLAIMS – SEVERITY

1	Death
2	Brain Damage
3	Nerve Damage
4	Medication Error
5	Stroke
6	Tissue Injury
7	Aspiration
8	OR Fire
9	Failure to Diagnose
10	Vision Loss



*2015-2024

TOP 10 CLAIMS CLOSED WITH PAYMENT



* 2020-2025

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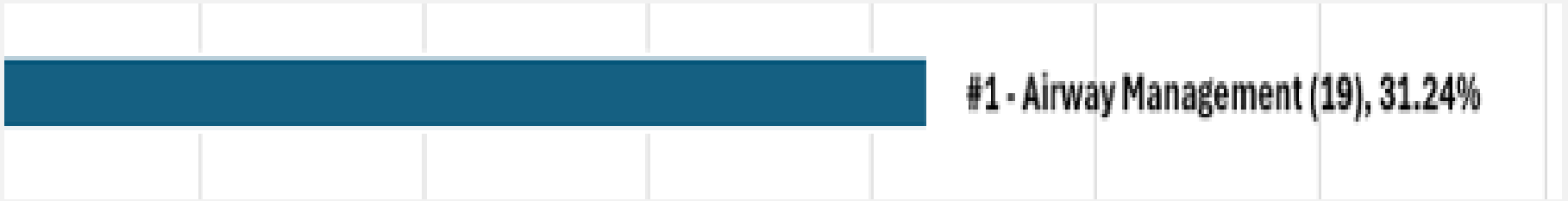


AIRWAY MANAGEMENT

COMMON CLAIMS & ALLEGATIONS

Can't Intubate, Can't Ventilate –

Improper plan for induction, failure to review medical Hx, airway devices not readily available

Time to Definitive Airway –

Improper airway device, failure to timely respond to signs of respiratory distress, failure to abort procedure

Early Extubation –

Lack of vigilance, failure to recognize patient did not meet extubation criteria, neglecting to apply transport monitors

Aspiration –

Failure to appreciate risk factors, improper anesthesia plan and/or airway device selection, lack of communication

Airway Trauma –

Improper technique, failure to stop/reschedule procedure, misuse of patient selection criteria (student trainees)

AIRWAY MANAGEMENT – CASE STUDY

- A 43 y.o. female presented to ASC for a knee arthroscopy and bunionectomy; patient's medical history was significant for obesity (37 BMI), GERD, and chronic pain
- During patient's pre-anesthesia evaluation, anesthesiologist noted decreased hyomental distance, small mouth, large incisors, and increased aspiration risk; patient's airway classified as Mallampati 4
- Anesthesia plan was GA with RSI; however, facility did not have a video laryngoscope
- Following RSI, anesthesiologist made three attempts to intubate patient without success (two under direct laryngoscopy and one nasal attempt); LMA placed between attempts to ventilate patient intermittently
- Patient developed laryngospasm following third attempt; anesthesiologist administered another dose of succinylcholine, but it did not resolve; patient went into cardiac arrest

AIRWAY MANAGEMENT – CASE STUDY

- During code, anesthesiologist called for surgical airway assistance, and two plastic surgeons responded to the OR; however, tracheostomy attempts were unsuccessful
- EMS arrived and a paramedic was able to intubate patient with a video laryngoscope; ROSC noted shortly thereafter, and the patient was transferred to a high acuity facility
- Aortic balloon pump was placed in cath lab (patient's EF was < 20%), respiratory and metabolic acidosis were managed, and a chest tube was placed to treat pneumothorax
- Once stabilized, patient returned to the OR for tracheostomy; cardiac function returned to near baseline on POD #2; patient remained on a ventilator for six days and was discharged after 17-day admission
- No findings of brain ischemia or acute cerebral function compromise during admission
- Discharge diagnoses: resolved cardiopulmonary arrest, cardiogenic shock, acute respiratory failure with hypoxia, hyperglycemia, pneumothorax, closed rib fracture, acute kidney injury, and hypokalemia

AIRWAY MANAGEMENT – CASE STUDY

- Patient filed a lawsuit against anesthesiologist and surgery center, alleging:
  - Failure to perform adequate airway evaluation prior to induction
  - Improperly performing procedure at surgery center
  - Failure to provide proper ventilation during surgery
  - Failure to use advanced airway rescue devices to ensure adequate ventilation
- Defense anesthesiology experts expressed concerns regarding:
  - Lack of video laryngoscope and proper rescue equipment onsite
  - Proceeding with case at ASC considering airway evaluation; or in the alternative, failing to modify anesthesia plan (awake intubation or procedure under block/local)
  - Failure to timely recognize situation was progressing towards CICV event

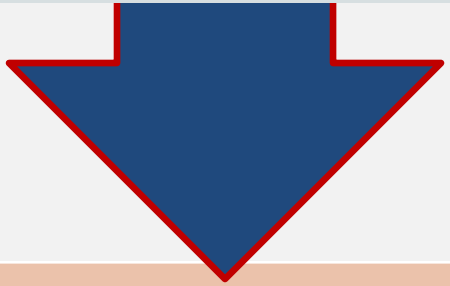
AIRWAY MANAGEMENT – CASE STUDY

Additional factors that complicated defensibility of the case:

Anesthesiologist prepared several "drafts" of anesthesia record, which had to be disclosed during litigation

Anesthesia group approached surgery center about obtaining video laryngoscope one year before event, but they did not follow up

During course of litigation, patient's alleged damages evolved from depression, anxiety, and PTSD to a brain injury diagnosis



Case resolved within policy limit at mediation

AIRWAY MANAGEMENT – CAN'T INTUBATE, CAN'T VENTILATE

RISK MANAGEMENT STRATEGIES

1. Patient Selection – Develop and apply objective criteria; don't let production pressures or professional relationships influence decisions involving patient safety

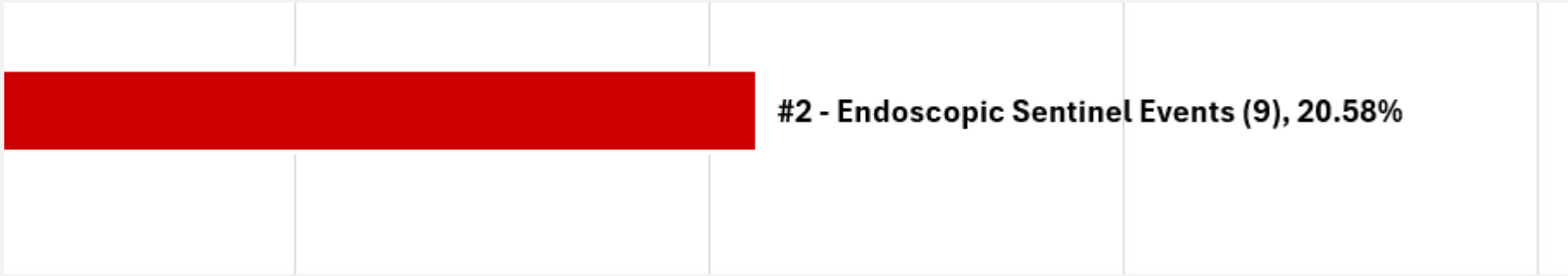
2. Equipment & Resources – Ensure facility has appropriate equipment and rescue medications to manage foreseeable complications; make sure they're readably available if difficult airway is anticipated

3. Informed Consent – Bolster informed consent process: during discussion with patient, highlight both the specific risks and alternative plans (awake intubation, undergoing the procedure without GA, etc.)

4. Guidelines – Follow difficult airway algorithm

5. Cancel Case if Necessary – Abort procedure and administer reversal agents if initial attempts are unsuccessful

#2



ENDOSCOPIC SENTINEL EVENTS – PPM LOSS DATA

- Increased number of claims and lawsuits arising from complications during endoscopic procedures; many resulting in catastrophic injuries, such as brain damage and death
- 10 closed claims with payments 2015 – present (8 deaths, 2 brain injury):
    - Indemnity = $9.5M
    - Defense Costs = $2.14M
- 2 pending lawsuits alleging patient death or brain injury during elective endoscopic procedure
- 12 open incidents reported involving patient deaths

ENDOSCOPIC SENTINEL EVENTS – CASE STUDY

- 76 y.o. male, hx included obesity, probable OSA, dyspnea on exertion, a-fib, CAD, MI, ischemic cardiomyopathy (EF 35%), HTN, chronic renal insufficiency, DM, s/p CABG, presented for an elective EGD and colonoscopy
- On admission to the endoscopy center, his O2 SAT was 86%. This was charted by a nurse but not further evaluated or communicated to the anesthesiologist
- Anesthesiologist discussed the patient's multiple co-morbidities with the endoscopist who assured her it was "safe to proceed"
- Two 40 mg doses of propofol were given and within minutes the patient became hypoxic and bradycardic

ENDOSCOPIC SENTINEL EVENTS – CASE STUDY

- Anesthesiologist administered ephedrine to treat bradycardia but it quickly progressed to PEA. Code was called and resuscitation measures were initiated
- Patient transported to hospital but never regained consciousness and was diagnosed with profound hypoxic brain damage. He expired two weeks later when his family removed supportive measures
- The patient's wife originally sued the anesthesiologist and the endoscopy center only; the gastroenterologist brought in mid-litigation
- She alleged the procedure should have been performed in a hospital, if at all, and should have been deferred because of the low O2 SAT noted on admission that persisted despite supplemental O2

ENDOSCOPIC SENTINEL EVENTS – CASE STUDY

Plaintiff's anesthesiology expert:

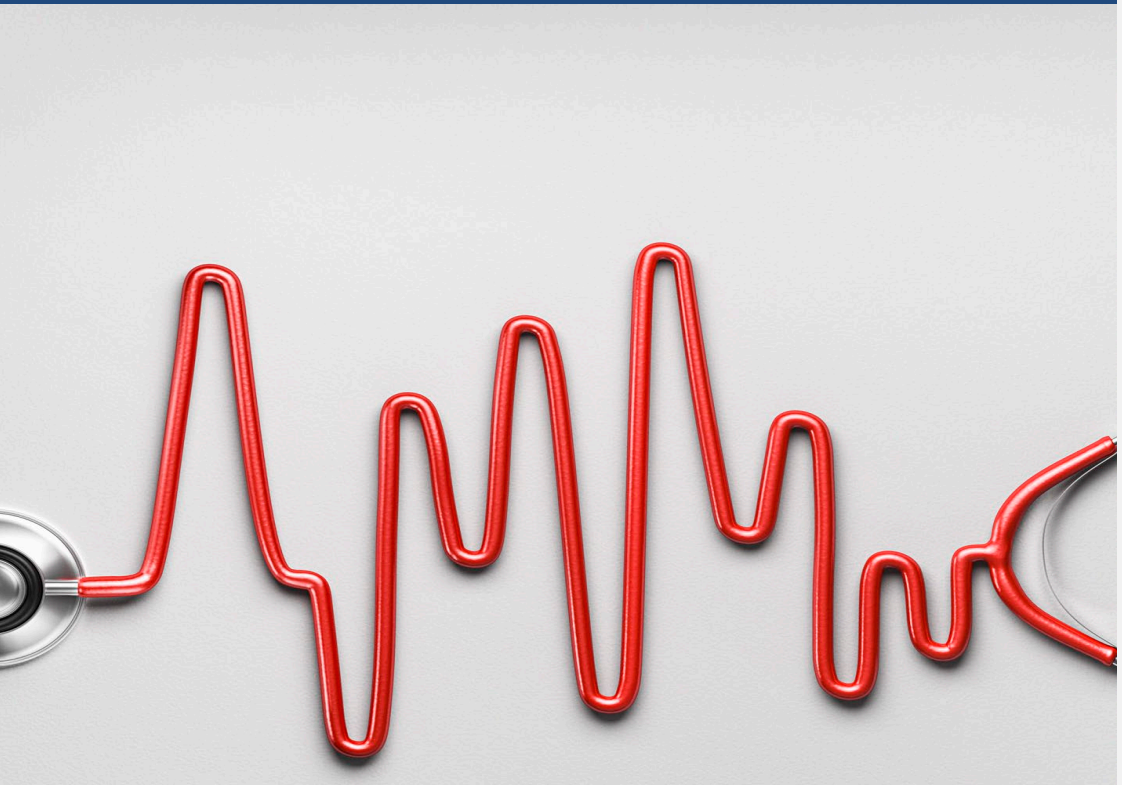
- Patient's medical hx too complex for procedure to be conducted at endoscopy center
- Procedure should have been canceled due to patient's baseline O2 sat of 86%. Evaluation of his respiratory and cardiac status should have been initiated
- Hypoxia/cardiac arrest - predictable consequences of sedation

Defense anesthesiology experts:

- Anesthesiologist failed to adequately assess the patient's significant co-morbidities
- Patient should have been designated an ASA IV
- Anesthesiologist should not have relied on the endoscopist's assurances that it was "safe to proceed"; too deferential

ENDOSCOPIC SENTINEL EVENTS

RISK MANAGEMENT STRATEGIES



- Consider whether patient is appropriate candidate for planned procedure at the facility; document any discussions with the endoscopist in the medical record
- If medically indicated, delay or cancel the procedure for further evaluation and treatment
- When appropriate, administer minimal or moderate sedation or general anesthesia via endotracheal tube or LMA
- Heightened vigilance for TIVA cases
- Deliver oxygen via non-rebreather mask with a sampling device used for qualitative ETCO2 measurement
- Aggressive treatment of bradycardia

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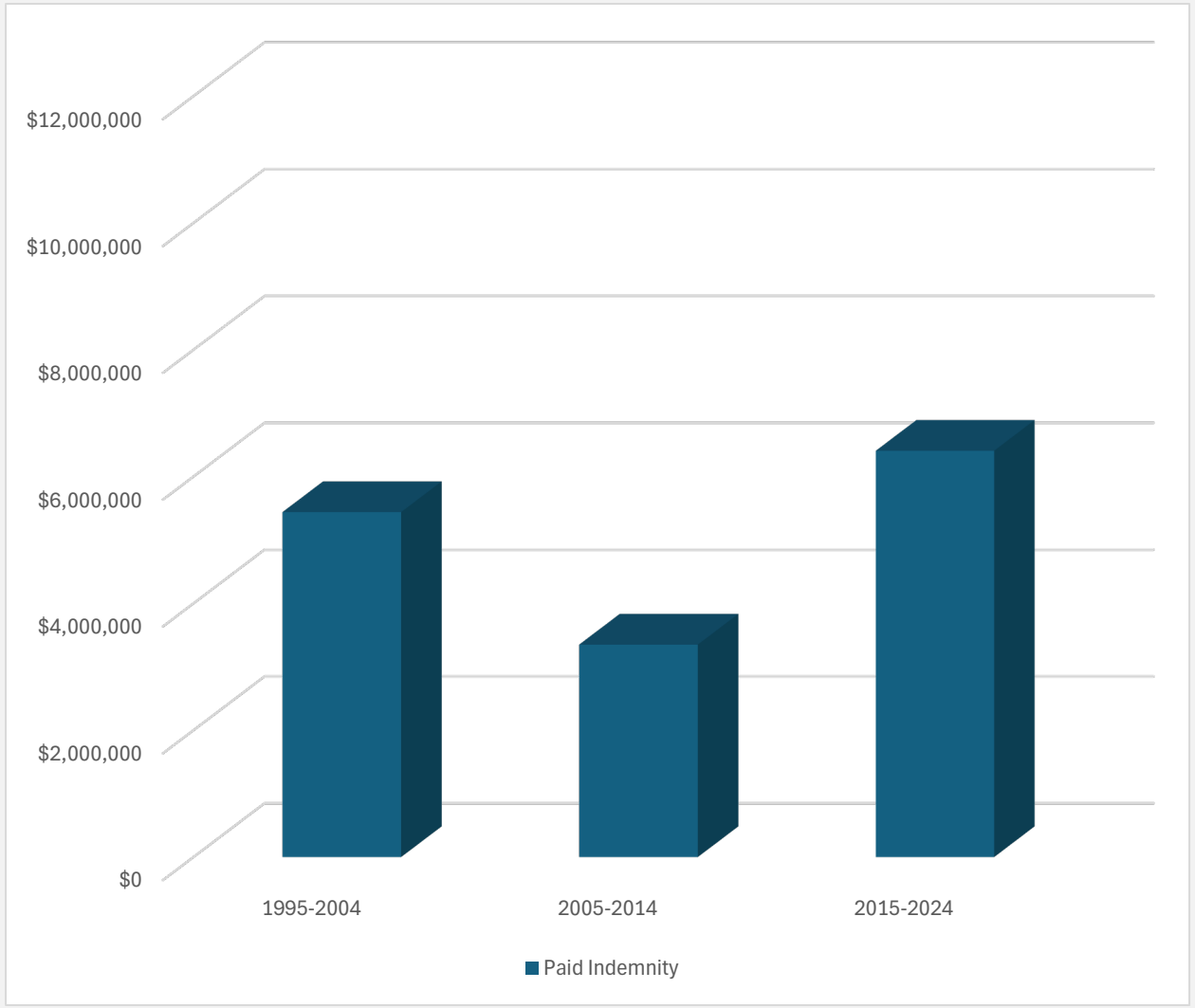
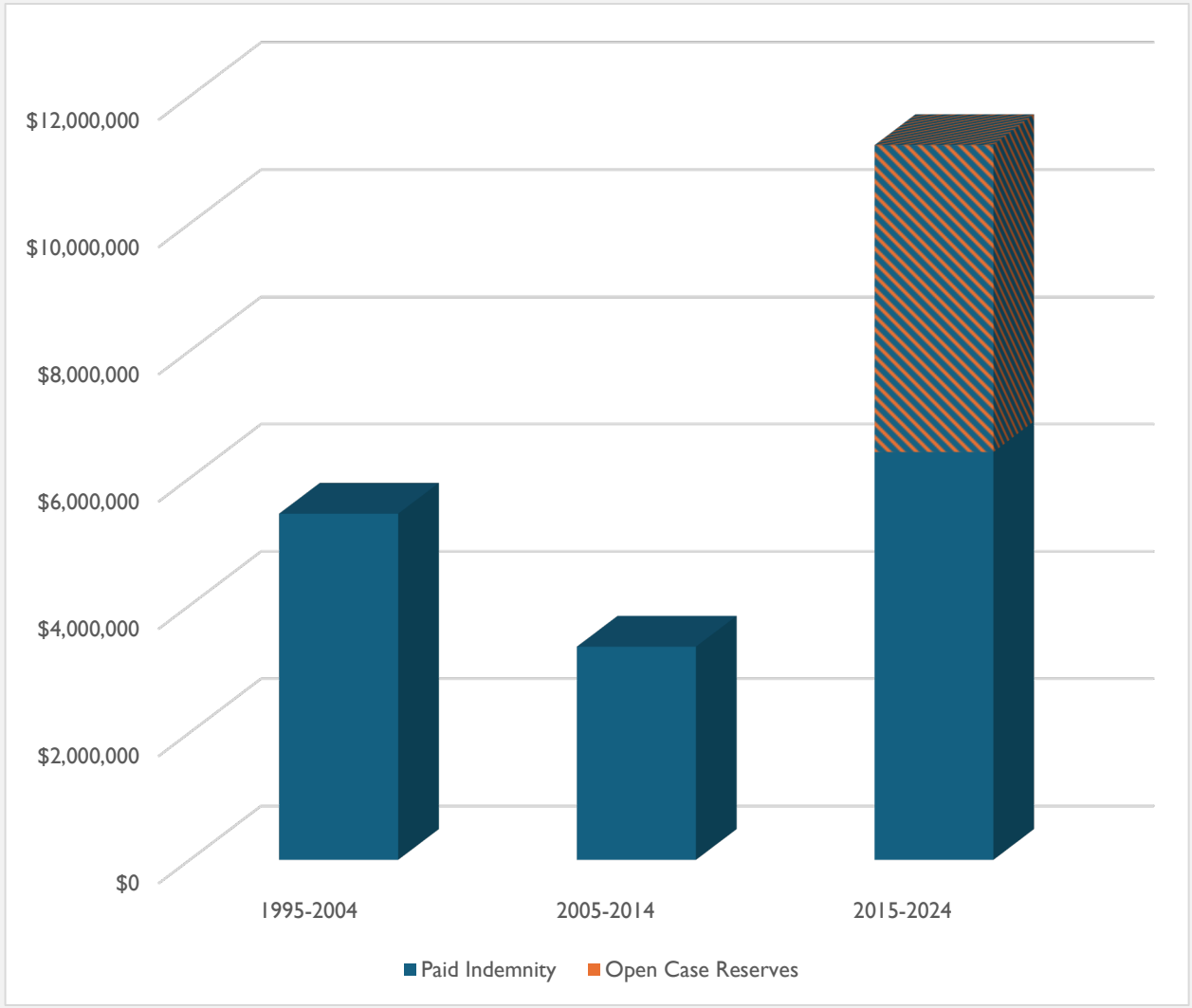
MEDICATION ERRORS - PPM LOSS DATA

- 251 medication errors reported
- 84 resulted in a claim or lawsuit
- Indemnity paid = $18M
- Defense costs = $4M
- 22 claims settled for >$100,000
- 5 intrathecal TXA cases settled = $6,385,000
- 4 open intrathecal TXA incidents and claims reported



MEDICATION ERRORS

PPM LOSS DATA



MEDICATION ERRORS

PPM LOSS DATA

MEDICATION ERRORS: TRANEXAMIC ACID - CASE STUDY

- 59-year-old female presented for total (r) hip replacement performed under spinal anesthesia
- Two CRNAs were setting up anesthesia trays
- One CRNA drew up the medication in the syringes while the other CRNA initialed and dated them
- Syringes were labeled with white and grey stickers for the bupivacaine and tranexamic acid, respectively

MEDICATION ERRORS: TRANEXAMIC ACID - CASE STUDY

- Shortly after administration of spinal the patient complained of low back pain and buttock itching
- Block was incomplete and patient was moving so converted to general anesthetic
- Post-op patient did not wake up and exhibited seizures in PACU
- Later determined patient received an intrathecal injection of tranexamic acid instead of bupivacaine
- Catastrophic neurologic injuries; long-term rehab facility

MEDICATION ERRORS: TRANEXAMIC ACID - CASE STUDY

- Investigation failed to determine which CRNA might have drawn up or labeled the wrong medication
- Anesthesia group and hospital informed patient's husband a medication mix-up had occurred
- Husband sued supervising anesthesiologist, both CRNAs, anesthesia group and hospital
- Case settled on behalf of the supervising anesthesiologist, both CRNAs and the anesthesia group for $2,000,000 policy limits

- After this incident, the anesthesia group implemented a new policy requiring all spinal tray medications to be checked by a second party prior to administration
- The policy also mandates that bupivacaine is not to be opened or prepared until the time of actual administration
- Anesthesia professionals should also consider working with the pharmacy to prepare spinal kits or have medications like tranexamic acid pre-mixed in IV infusion bags

MEDICATION ERRORS & LIABILITY

COMMON CAUSES & ALLEGATIONS

- Systems issues: normalization of deviance; production pressures
- Momentary lapse in concentration or situational awareness
- Look-alike vials; sound-alike drug names
- Dosage and drug concentration errors
- Lack of knowledge of patient's drug allergy history
- Drug shortages

MEDICATION ERRORS – RISK MANAGEMENT STRATEGIES

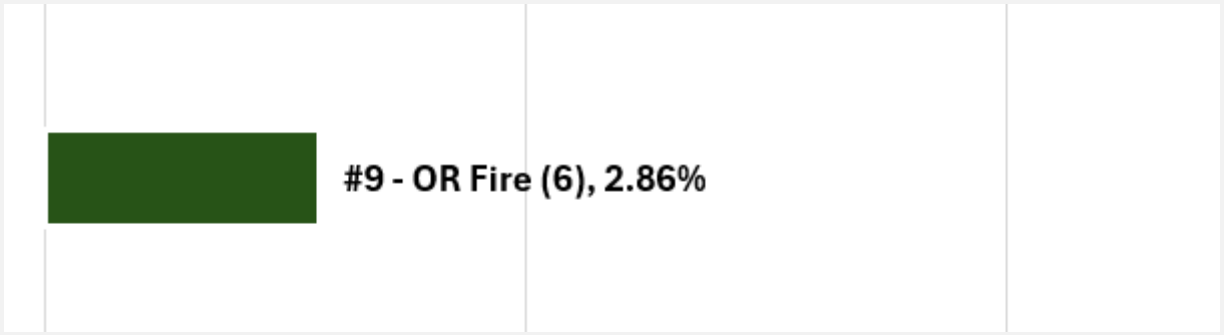
Technology – Facilities should implement systems and processes including bar code scanning systems, computerized physician order entry systems and automated information systems

Collaborate – Clinical pharmacists should be part of OR team, prefilled syringes and pre-prepared medication kits should be used whenever possible

Culture – Create a Culture of Safety for reporting errors (including near misses), education, remediation, and accountability

READ THE LABEL CAREFULLY

#9



OR FIRE – ELEMENTS

Ignition Source

Electrocautery, Laser, Defibrillator

Fuel

Alcohol-Based Prep Solution, Drapes, Towels, Gauze, Sponges, Hair

Oxidizer

Supplemental O2 (especially from open sources like nasal cannulas masks), Nitrous Oxide

- Majority of cases involve head and neck procedures, supplemental O2, alcohol-based prep solutions, and electrocautery
- 56 closed intraoperative fire cases – Indemnity = $6,6M; LAE = $2.3M

OR FIRE – CASE STUDY

OR FIRE – CASE STUDY

- 49 y.o. female presented for chemo port placement; hx was significant for metastatic breast cancer
- MAC case with face mask, O2 at 3-4 liters initially, increased to 6 liters due to difficulty maintaining O2 sats, then back to 4 liters
- Patient prepped twice, CRNA recalls feeling prep solution on patient's chin with chin lifts
- CRNA turned to chart, surgeon starts electrocautery, sees orange glow under drapes and yells "fire"
- Drapes pulled back, flash of fire, mask removed, water splashed on fire and burned areas of patient's face and shoulder, and patient was intubated
- Patient transferred to burn unit at another hospital then on to a rehab facility
- NOI submitted against the CRNA, surgeon, and hospital. Case settled at mediation with each party contributing equally to a $750K total settlement

OR FIRE

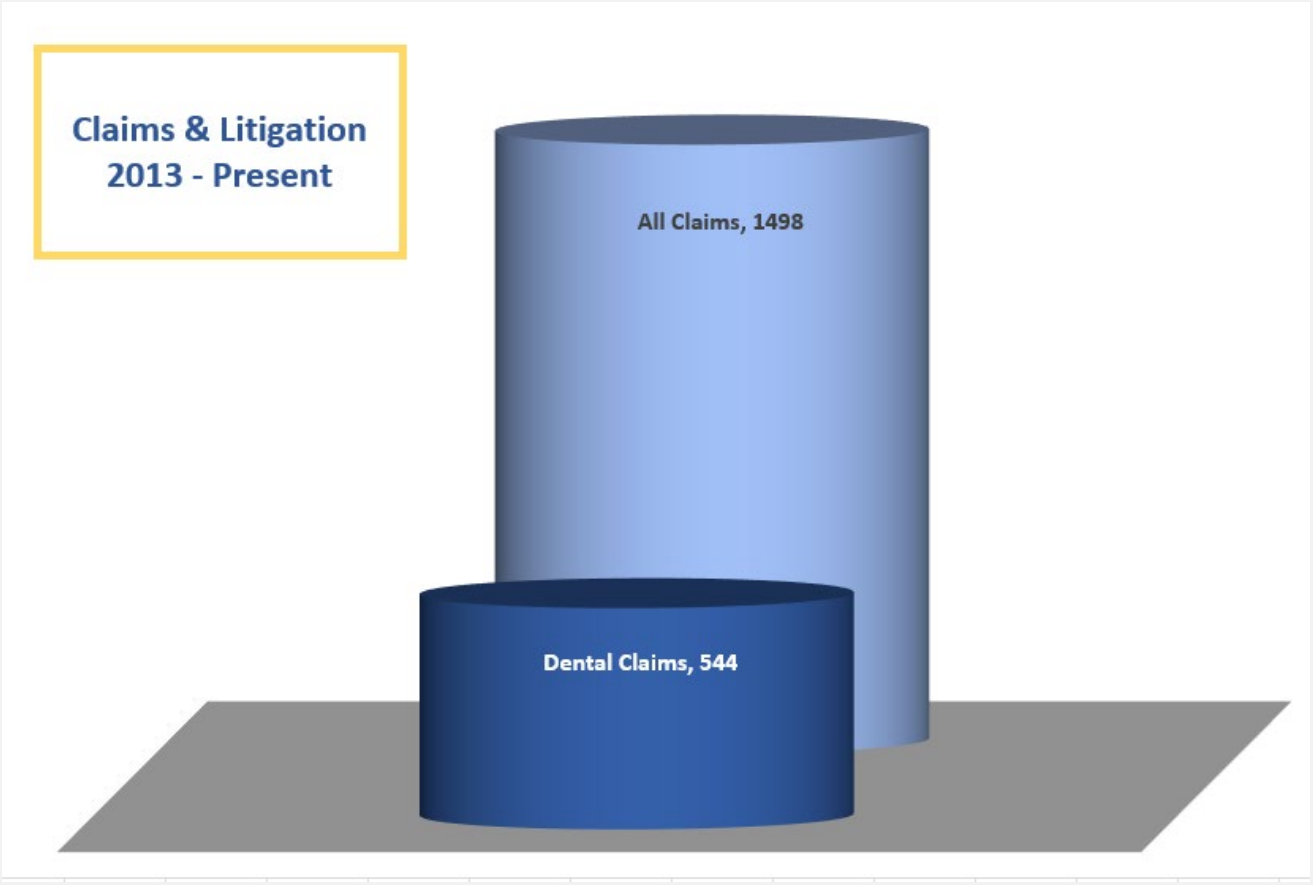
EXPERT CRITICISMS

- No fire risk assessment, time-out protocol, or other fire prevention plan
- Alcohol-based prep solution not allowed to dry
- No communication between surgeon and anesthesia provider before electrocautery use
- O2 was not turned down or off before electrocautery use
- No plan in place to manage OR fire

OR FIRE – PREVENTION STRATEGIES

- Hospital/facility should have OR fire prevention protocol, including fire risk assessment and time out
- Minimize or avoid an O2 enriched atmosphere near surgical site (consider ETT or LMA, turn down/off O2 before ignition source use, <30% FiO2)
- Configure drapes to minimize accumulation of O2
- Allow sufficient drying time for alcohol-based/flammable skin prep solutions
- Moisten sponges and gauze when used in proximity to ignition sources
- Active communication and timing between anesthesia professional and proceduralist is paramount

https://www.apsf.org/videos/or-fire-safety-video/



DENTAL CLAIMS – RISK MANAGEMENT

- Dental injury is PPM's #1 reported adverse event
- January 2013 - present:
  - 992 dental injury incidents reported
  - 544 resulted in claim investigation

PERIOPERATIVE DENTAL TRAUMA CASE STUDY

58 y.o. female presented for shoulder arthroscopy. Insured anesthesiologist supervising SRNA. Patient was a Mallampati 2 and had a cap on her upper teeth

SRNA attempted intubation and the capped tooth broke at the gumline

Patient's family notified and they remarked that "that tooth was not a strong tooth to begin with"

Plaintiff filed suit against the anesthesiologist and the hospital

Hospital settled with the plaintiff for $10,000; plaintiff's attorney dismissed case against the insured

DENTAL CLAIMS – WHAT TO DO IF DENTAL INJURY OCCURS

Risk management strategies to avoid dental claims:

- Informed consent form should list risk of dental injury
- Discuss risk of dental injury and document discussion
- Document condition of dentition in detail
- Take out removable dental appliances; if left in place for clinical reason, document rationale

What to do if dental injury occurs:

- Recover teeth fragments or prosthesis, save for the patient
- Do not accept responsibility for dental repairs before investigation is complete
- Refer patient to their dentist
- Contact PPM to discuss options for handling
- If group decides to reimburse a patient as a goodwill gesture, ALWAYS obtain a release

THANK YOU!

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