



Physician Series

Manual on Professional Liability



American Society of
Anesthesiologists 



Manual on Professional Liability

An informational manual compiled by
the ASA Committee on Professional Liability

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INTRODUCTION

The specialty of anesthesiology has always led in the area of patient safety. This has resulted in a marked reduction in the occurrence of anesthesia-related patient injury, and concomitant reduction in premiums for professional liability insurance. Nevertheless, regardless of the quality of care, poor outcomes cannot always be avoided. Malpractice claims may be filed due to a poor outcome even with appropriate care in which no error was made. Although the number of malpractice claims is lower than reported adverse events,¹ anesthesiologists practice in a high-risk critical care environment, and therefore are highly likely to face malpractice claims.

Insights into the most common factors that influence potential for malpractice suits should inform us regarding precautions that may reduce the risks of liability. Furthermore, understanding the process of a lawsuit as well as knowledge of commonly made mistakes when facing a lawsuit, should help in dealing with a claim.

It is our aim that the information presented in this manual will minimize the risk of a lawsuit through practice modification and improve the defensibility of an adverse event if a claim or lawsuit were to occur.

Malpractice Statistics

Malpractice Statistics: All Physicians

There are approximately 125,000 active lawsuits against all physicians in the system on a daily basis (AMA Analysis, JAMA Medical Education Edition, 2005). The majority of these (75 percent) result in nonpayment, and over 80 percent of cases that proceed to trial end in a defense verdict for the physician (Physician Insurers Association of America, 2005). However, the defense of a dropped or dismissed claim averages \$19,000, while the average defense costs of a claim that proceeds to trial with a defense verdict is \$94,000 (Physician Insurers Association of American, 2005). These factors drive up the cost of healthcare by direct and indirect costs of defensive medicine. Furthermore, they limit access to services for patients because of physicians moving out of state or eliminating services from their practices. Tort reform has been shown to reduce the cost of state healthcare expenditures and to increase the supply of physicians.^{2,3} Although the vast majority of states have some element of tort reform, the type, applicability, and economic caps vary widely between states.

Since 1990, federal law has mandated that all licensed health care practitioners must be reported to the National Practitioner Data Bank (NPDB) if a malpractice payment is made on their behalf. The NPDB provides a sampling of national statistics on medicolegal payments, although 52 percent of hospitals had never submitted any NPDB reports as of 2004.⁴ Reporting of state licensure, clinical privileges, and professional society membership actions to the NPDB is required only for physicians and dentists, making these data invalid for comparison between professions.

Data from the NPDB revealed that the number of reports made for all physicians in 2005 (n=14,034) had declined from 2001 (n=16,589). However, the inflation-adjusted median payments were increased (\$174,569 in 2005 compared to the cumulative median since 1990 of \$128,764). Obstetrics-related cases accounted for the largest percentage of physician reports in 2005 (9.0 percent) and the highest median payments (\$300,000). Regional variation exists in the number of reports filed, as lawsuits are more frequently filed in urban areas and in eastern or western states. However, much of this variation may be explained by population. Of the NPDB physician reports filed between 1990 and 2005, New York accounted for 13.5 percent, California 10.8 percent, Texas 7.5 percent and Florida 7.4 percent. Awards vary dramatically by state (median payments of \$59,618 to \$375,000) as well as length of time from incident to payment (median time of 3.2 to 6.2 years), with a median payment delay of 4.1 years. Previous work has demonstrated that the only factor predictive of successful litigation in a medical malpractice suit is the severity of patient disability. Occurrence of an error or an adverse event associated with negligence was not predictive of outcome.⁵

Malpractice Statistics: Anesthesiologists

Anesthesia-related cases accounted for only 3.3 percent of 2005 NPDB reports, but the median payment was relatively large (\$200,000) and was significantly increased compared to the cumulative inflation-adjusted median since 1990 (\$119,226). The median time in 2005 from incident to payment was 4 years. The long duration of these lawsuits can cause enormous psychological stress, leading many physicians to seek professional counseling.

Advances in anesthesia devices, drugs, techniques and clinical practice over the last several decades have improved patient outcomes and resulted in significantly decreased medicolegal liability for anesthesiologists. These advances have been attributed primarily to an aggressive and proactive approach by the ASA to reduce anesthetic complications, and thereby, reduce our exposure to medicolegal liability. The ASA Closed Claims Project, the Anesthesia Patient Safety Foundation, and the Foundation for Anesthesia Education and Research have diligently worked to improve anesthetic outcomes over the last two decades and establish our reputation as a patient safety focused profession. The ASA has also developed over 71 practice parameters, standards, guidelines, and statements designed to improve patient safety and outcomes. The proportion of closed malpractice claims associated with death and brain damage from the ASA Closed Claims Project decreased from over half of claims in 1975 to approximately one quarter in 2000.⁶ Consequently, our profession has been “rewarded” by seeing a dramatic decline in our average malpractice premiums (adjusting for inflation) from \$32,502 in 1985, at the height of our professional liability crisis, to \$19,558 in 2006.⁷

Despite these improvements, the intersection of patient illness and potentially lethal drugs and techniques in anesthesia will always provide a fertile ground for medicolegal liability. In addition, increasing performance of highly invasive procedures

(such as cervical blocks or injections) in chronic pain management has also increased liability. Vicarious liability from supervision of mid-level care providers (see section on Vicarious Liability), health care systems issues, and other medical specialists involved in the care of the patient may draw anesthesiologists into lawsuits despite appropriate care on their part. The number of times an anesthesiologist gets sued in his/her lifetime may vary depending on the years in practice, the medicolegal climate in the region of practice, the supervisory ratio of mid-level care providers, the acuity of patient illness, practice in high-risk subspecialties (e.g., obstetrics, neurosurgery), and practitioner specific characteristics.

DEFINITION OF MALPRACTICE

Malpractice refers to any professional misconduct, but its use in legal terms typically refers to professional negligence. To be successful in a malpractice suit, the patient-plaintiff must prove the four elements of negligence: duty, breach of duty, causation, and damages. Failure to prove any one of these conditions will result in a decision for the defendant-anesthesiologist.

1. **Duty:** the patient-plaintiff must prove that the anesthesiologist owed him or her a particular duty or obligation.
2. **Breach of Duty:** the patient-plaintiff must show that the anesthesiologist failed to fulfill his or her obligation.
3. **Causation:** the patient-plaintiff must demonstrate a reasonably close causal relationship between the anesthesiologist’s acts and the resultant injury.
4. **Damages:** the patient-plaintiff must show that actual damage resulted because of the acts of the anesthesiologist.

Duty

When the patient is seen preoperatively and the anesthesiologist agrees to provide anesthesia care for the patient, a doctor-patient relationship is established, which constitutes a duty to the patient. In the most general terms, the duty that the anesthesiologist owes to the patient is to adhere to the “standards of care” for the treatment of the patient.

The legal standard of care is defined traditionally as “the degree of care and skill that a physician of the same medical specialty would use under similar circumstances.” However, this is not defined uniformly throughout the United States, but will depend on the state law in question. Some state courts have created the “reasonable and prudent” physician approach. This means a physician will be held accountable for what a reasonable and prudent physician under similar circumstances at the time of the treatment in question. Under the “locality rule,” this means what a physician in the same or similar locality would have done. Other states apply a national standard

of care. What this means in practical terms is that an anesthesiologist may be held accountable for his or her actions according to what any reasonable and prudent anesthesiologist, from anywhere in the United States, would do or not do under the same or similar circumstances. It is not sufficient that the individual anesthesiologist acted to the limits of his or her potential, acted in good faith or did what was considered normal in that hospital or another hospital in the same region. A recent study found that most jurisdictions (29 states and Washington, D.C.) use a national standard of care.⁸ However, a significant minority (21 states) uses some version of a locality standard of care.⁸ In addition, there may be more than one standard of care or accepted standard of medical practice. Therefore, the standard of care may not necessarily reflect what the majority of physicians would do, but what may be acceptable medical practice according to a respectable minority of physicians.

Since medical malpractice usually involves issues beyond the comprehension of lay jurors and judges, the court establishes the standard of care in a particular case by the testimony given by “expert witnesses.” Expert witnesses differ from factual witnesses mainly in that they may give opinion based upon scientific, technical or other specialized knowledge. Sometimes the success of a suit depends primarily on the stature and believability of the expert witnesses. In certain circumstances, the standard of care also may be determined from published professional society guidelines, written policies of your hospital or department, or textbooks and monographs.

There are certain general duties that all physicians have to their patients, and breaching these duties may also serve as the basis for a lawsuit. One of these general duties is the duty to obtain an informed consent (see the section on Informed Consent). Other general duties include the maintenance of medical records, the adherence to privacy laws, the performance of an appropriate examination of the patient and the use of consultations and referrals to other physician specialists. Although these duties are more applicable to the primary care specialties, anesthesiologists may be held liable for the failure to perform these general duties as they are applied to the specialty. For example, if an anesthesiologist performs a preoperative examination for another anesthesiologist or a nurse anesthetist and fails to provide adequate documentation in the medical record or to report a significant condition by direct consultation, he or she will be liable for any injury that results if it was caused by the failure in question and damages are proven.

Breach of Duty

The expert witnesses will review the medical records of the case as well as depositions of the defendants and other witnesses. Based upon the review, they will determine whether the anesthesiologist acted in a reasonable and prudent manner in the specific situation and fulfilled his or her duty to the patient. If they find that the anesthesiologist either did something that should not have been done or failed to do something that should have been done, then the duty to adhere to the standard of care has been breached, and the second requirement for a successful suit will have been met.

Causation

Most physicians have difficulty understanding that legal causation differs significantly from medical causation. Since physicians plan to offer treatment for a specific condition, they usually attempt to find the most immediate or direct medical cause of the problem in addition to understanding all aspects of the patient’s condition. Judges and juries are interested in determining whether the breach of duty was the “proximate cause” of the injury.

The term “proximate cause” means the efficient cause setting in motion a chain of circumstances leading to the injury, and proof in this context means only more likely than not. If the odds are better than even that the breach of duty led, however circuitously, to the injury, then this requirement is met.

There are two common tests employed to establish causation. The first is the “but for” test, and the second is the “substantial factor” test. If the injury would not have occurred but for the action or omission of the defendant-anesthesiologist, or if the action of the anesthesiologist was a substantial factor in the injury despite other causes, then proximate cause is established. In addition, evidence that a reasonable and prudent anesthesiologist would have foreseen that the event, or some similar event, might result from his or her action or omission may establish proximate cause.

While the burden of proof of causation ordinarily falls on the patient-plaintiff, it may, under special circumstances, be shifted to the physician-defendant under the doctrine of *res ipsa loquitur* (“the thing speaks for itself”). Applying this doctrine requires proving that:

1. The injury is a kind that typically would not occur in the absence of negligence.
2. The injury must be caused by something under the exclusive control of the anesthesiologist.
3. The injury must not be due to any contribution on the part of the patient.
4. The evidence for the explanation of events must be more accessible to the anesthesiologist than the patient.

Because anesthesiologists render patients insensible to their surroundings and unable to protect themselves from injury, and because anesthesiologists assume responsibility for doing so, this doctrine is more likely to be invoked in anesthesia malpractice cases than in other malpractice cases. All that needs to be proven is that the injury typically would not occur in the absence of negligence, and the anesthesiologist is put in the position of having to prove that he or she was not negligent.

TYPES OF DAMAGES

The law allows for three different types of damages – general, special, and punitive or exemplary. **General damages** are those such as pain and suffering which

directly result from the injury. **Special damages** are those actual damages that are a consequence of injury such as medical expenses, lost income, and funeral expenses. **Punitive damages** are intended to punish the physician for negligence that was reckless, wanton, fraudulent or willful. **Exemplary damages** are awarded for the same reasons as punitive damages, the difference being semantic. In an award of exemplary damages, there is no intent to punish the physician, but rather to make an example of that case to prevent any other physician from doing the same thing again.

MAGNITUDE AND FREQUENCY OF PAYMENTS

Determining the dollar amount of damages is the job of the jury, and it is usually based upon assessment of the plaintiff's current condition compared with the condition that person would have been in if there had been no negligence. Plaintiffs' attorneys generally charge a percentage of the damages and will, therefore, seek to maximize the award given.

There is a widespread belief among physicians and the lay media that decisions for the plaintiff and the amounts of the award in medical malpractice lawsuits are without merit. However, a number of studies have conclusively shown this to be false. Plaintiffs prevail in only about 25 percent of malpractice cases that go to trial. In these instances, the amount of the malpractice award is directly correlated with the severity of the negligence and the injury.⁹⁻¹³ This has been shown also to be true for studies looking at anesthesia-related claims.¹⁴ In cases that do not proceed to trial, the results are similar: the likelihood of a settlement and the size of the settlement are both closely related to the strength of the claim (i.e., poor quality of the medical care).¹⁵ Overall, of the approximately 60,000 claims filed annually in the United States, only about 30 percent close with payment to plaintiffs.¹⁶

HOW TO MINIMIZE THE RISK OF LIABILITY

Physician-Patient Relationship

A number of studies have attempted to determine the characteristics of patients that bring medical malpractice suits against their physicians. Assuming an "even playing field" (i.e., equal quality of medical care), patients who sue are more likely to be unhappy with the interpersonal relationship with their physician than the actual outcome of the care they received. Following an adverse event that may or may not involve negligence, patients report greater satisfaction and are less apt to sue when they perceive the physician as communicative, caring, honest, personal, and apologetic, when appropriate.^{17,18}

An important aspect of the physician-patient relationship is the anesthesiologist's ability to project a professional image to the patients and their family. Appearance and demeanor at the bedside are major contributions toward establishing this image.

If the patient or their family gets an initial impression that the anesthesiologist is sloppy, flippant, careless, and poorly informed, there is a higher likelihood of litigation after an adverse outcome.

Patients sometimes sue merely to get information when they perceive that it is being withheld or that their physician is being less than forthcoming. Non-physician factors that increase the likelihood that a patient will sue include television advertising by law firms, recommendations by other health care workers to seek legal advice, and unique situations of financial constraint.^{19,20} In fact, patients' calls to law firms are often initiated after receiving notice that their unpaid bills were referred to a collection agency.

From a review of the literature, it appears that the most effective way for physicians to avoid lawsuits is to be open and honest with their patients, especially when a complication occurs. Physicians should be readily available for communication with their patients that have suffered complications. In the event of a complication that may or may not be caused by physician negligence, the physician should closely collaborate with the hospital's division of risk management to proactively approach the patient and/or the family and decide upon a corrective course of action. In general, patients that have suffered complications do not want financial compensation, but rather desire an analysis of the root causes and implementation of corrective and preventative measures.²¹

Informed Consent

The concept of informed consent is rooted in the fundamental ethical principle of the right of self-determination. This principle recognizes that patients are autonomous, that is, they are independent agents with the capacity to make decisions regarding their well being without coercion from others. The medical-legal concept of informed consent was first introduced in the 20th century. In 1957, *Salgo v. Trustees of Leland Stanford Hospital* (Cal.App.2d 560, 317 P.2d 170 [Sup. Ct. Appl.]) determined that the physician is required to explain the risks, benefits and alternatives of a proposed procedure to a patient. *Natanson v Kline* (186 Kan. 393.350 P.2d 1093) in 1960 further specified what information should be disclosed to a patient and introduced the "professional practice standard". This standard requires that a physician disclose to a patient what other physicians in the community would disclose under similar circumstances. In 1972, *Canterbury v Spence* (464 F.2d 772 D.C. Cir.) introduced the "reasonable person standard" which requires disclosure of information that a reasonable patient would consider important in making an informed decision.²² Today, 25 states and the District of Columbia utilize the "reasonable person standard" whereas 23 states embrace the "professional practice standard". Colorado and Georgia blend aspects of both standards.²³

There are several elements intrinsic to the informed consent process.²⁴ The term "competence" refers to a patient's legal authority to make decisions. Adult patients, generally considered patients who are 18 or older, are presumed legally competent to

make health care decisions unless otherwise determined by a Court. Consent to treat a minor must be given by a parent or legal guardian unless State law recognizes certain conditions that may qualify as an exception to the general requirement for parental or guardian consent. For example, depending upon the State, minors may be legally authorized to consent to their own health care if the patient is a parent; is pregnant and consenting for prenatal care; is married; is otherwise emancipated; or is in the active military.

“**Capacity**” refers to a determination (made by medical professionals) that a patient has the ability to make a specific decision at a specific time. To have capacity, patients must be able to understand and reason about their medical conditions, and to appreciate the indications, risks, benefits and alternatives to proposed treatments. It is the physician’s responsibility to determine if a patient lacks capacity to a reasonable degree of medical certainty. If a patient lacks capacity, consent must be obtained from an authorized decision maker, unless an emergency exists or another exception applies. State law will govern who will be considered a legally authorized surrogate decision maker. For example, depending on the laws, this person may be a designated health care proxy, spouse or an adult next-of-kin.

Securing a patient’s consent for medical treatment is a process requiring effective communication between doctor and patient.²⁵ The informed consent discussion should focus on the indications for the proposed treatment, a description of the procedure in terms a layperson can understand and an explanation of available alternatives. A frank disclosure of **material risks** of both the recommended and alternative treatments is important. Material risks are those that a reasonable person would want to be made aware of before deciding to undergo or reject the recommended therapy. Material risks include those that occur commonly, but have little long-term consequence as well as those that are rare but may result in severe, long-term morbidity or mortality.

A recent informal survey of anesthesiologists practicing at both private and academic institutions across the country revealed that the following “common” risks of general anesthesia are frequently disclosed: possible oral or dental damage, sore throat, hoarseness, postoperative nausea and vomiting, drowsiness and urinary retention. Disclosure of more severe risks includes possible awareness, postoperative visual loss, aspiration, negative pressure pulmonary edema, organ failure, malignant hyperthermia, drug reactions and the risk of failure to recover from the anesthetic, coma or death. For regional anesthetics, common risks often disclosed encompass prolonged numbness, “spinal headache”, backache and failure of the regional techniques. Less common but severe risks frequently discussed include bleeding, infection, nerve damage, persistent weakness or numbness, seizures, coma and death.

In addition to discussion of risks, benefits and alternatives, some States require disclosure of the identity of all persons reasonably anticipated to be involved in the patient’s anesthetic care.

Practitioner’s personal recommendation

An important part of the informed consent process is offering the patient one’s professional opinion of the best options given the anesthesiologist’s skill set, knowledge of the patient’s co-morbidities and the surgeon’s preferences. Important to this part of the discussion is an explanation of the pros and cons of the recommended technique as well as the back-up approach. It is important to appreciate the differences between persuasion, manipulation and coercion in presenting this information to the patient.

Autonomous authorization

Following a discussion of indications for the therapy, disclosure of material risks, benefits and alternatives, and having questions answered, the patient is in a position to make an informed decision. The patient’s authorization to proceed with a proposed course of treatment is an expression of his/her right of self-determination and is the basis for informed consent.

Documentation

It is important to record the informed consent process in the medical record. Some organizations rely on the surgical consent form to document consent for anesthesia. This practice is problematic as the consent document may be completed in the surgeon’s office before the patient has an opportunity to talk with an anesthesiologist. Reliance on the surgeon to conduct an informed consent discussion for anesthesia presumes that they are as competent as an anesthesiologist to do this. Many organizations are adopting a separate, written informed consent document for administration of anesthesia. Some States require this, but there are other reasons to consider using this approach: common risks of all techniques can be clearly detailed; patient specific risks can be added in long hand; the patient and a witness sign the form; and it allows efficient documentation of the informed consent process for the growing number of patients who require anesthesia for a non-surgical procedure.

Some organizations are relying on innovative approaches to document the informed consent discussion. Commercially available video demonstrations of various anesthetic techniques and enumeration of risks and benefits are used in some institutions to facilitate patient education and track the time and day the education was provided. Other groups are utilizing interactive web site-based education to document the informed consent process. Irrespective of what modality is chosen to document the process, it is important to be able to produce evidence that a meaningful informed consent discussion occurred.

Adhere to a “Standard of Care”

One of the tests of negligence is whether or not the anesthesiologist adhered to the standard of care in treating the patient. Since the standard is most often determined retrospectively by review of the records, it may not be feasible in all cases to know what the “standard” is. What this means in practical terms is that anesthesiologists

should keep current in their knowledge and provide medical care consistent with this knowledge. This does not mean that all anesthesiologists must be continually on the cutting edge of medical research, but it does require that they be aware of, and conform to, accepted standards and guidelines for the provision of anesthesia care as applicable.

The American Society of Anesthesiologists has published some standards and guidelines for the practice of anesthesia. *Standards* provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment. *Guidelines* are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert opinion, open forum commentary, and clinical feasibility data.²⁶

In terms of medical and anesthetic management of patients, adhering to the standard of care means that the choice of drugs and techniques is appropriate and that the anesthesiologist is competent in the use of these drugs and techniques. Prudence in the choice of drugs decreases the likelihood of a successful suit. Having made the appropriate choice of drugs and techniques, the anesthesiologist must use them appropriately.

As a general rule, an anesthetic record showing the maintenance of vital signs within a reasonable range for the patient is evidence of the appropriate conduct of anesthesia. In addition to maintaining vital signs appropriately, anesthesiologists must also ensure adequate oxygenation and ventilation.

Preoperative Evaluation

The anesthesiologist, as the perioperative physician, has taken the lead in establishing the framework in which patients are prepared for surgery and anesthesia. The number of cases filed for litigation due to improper preoperative evaluation and preparation remains small. In only 5 percent of claims in the ASA Closed Claims Project there appeared to be a breach of duty and causation resting upon the performance of the preoperative assessment. It is not clear what the impact of preanesthesia clinics and streamlined preoperative testing and screening modalities have made on the liability profile of anesthesia claims. Nevertheless, preoperative assessment remains vulnerable under any case of litigation and is subject to intense scrutiny. The particular medical legal vulnerabilities of preanesthesia evaluation include short-term contact with the patient, variability in the quality and timing of preanesthesia evaluation and the use of consultants.

The vulnerability of a short-term contact encounter by the anesthesiologist could be attenuated when patients are evaluated in a preanesthesia clinic, as there is an opportunity to develop a relationship with the patient and his/her family during the visit. In an unhurried session, the anesthesiologist, physician-directed nurse practitioner or physician assistant can obtain the informed consent and discuss with the patient the potential risks and benefits of the various anesthesia choices.

Preanesthesia Evaluation

The methods used for conducting pre-anesthesia evaluation vary widely. These include written or computerized questionnaires, telephone or virtual telemedicine interviews, or face-to-face visit at a preoperative anesthesia clinic. The personnel involved may be an anesthesiologist, nurse anesthetist, resident, physicians' assistant or nurse practitioner. Regardless of the method, completion of a preanesthesia evaluation that encompasses at least the basic ASA preanesthesia elements is required by CMS.²⁷ Interdisciplinary efforts to provide evidence-based algorithms continue to be developed and will serve as a benchmark against which clinicians are expected to perform. Anesthesia group practices should come to consensus about the minimum acceptable requirements for preoperative workup, and delineate the responsibilities for preoperative assessment if conducted by a different physician or physician extenders. The evaluation of the clinician doing the assessment should be consistent with the one administering anesthesia. To perform an inadequate evaluation could constitute a breach of the anesthesiologist's duty to the patient.

Laboratory Testing

Preoperative tests that are driven by legal protection from the fear of adverse consequences rather than evidence-based decisions are unlikely to reduce risk and liability. Large-scale randomized, prospective study of outcomes demonstrated that when patients are properly evaluated by their physicians before surgery, the number of preoperative laboratory tests can be reduced significantly without adversely affecting patient care.²⁸ The history and physical exam should drive the decision for test selection even if surgery had not been planned.

There should be a process in place to ensure that every ordered test is completed, every completed test is reviewed, and results are filed with the correct patient name and communicated to the patient along with the treating physician if any action needs to be taken. The preanesthesia clinic or preoperative staff should have a mechanism for managing laboratory tests and their findings, for taking action on test results and to safeguard patients and their privacy. One of the biggest liabilities occurs when abnormal test results are either misfiled [Flood v. Pendleton Mem., 823 So.2d 1002 (2002)] or filed in a medical record without being reviewed [Helderman v. Smolin, 179 S.W. 3d 493 (Tenn. App. 2005)]. A system should be in place for identifying abnormal tests and communicating them to the patient. The physician who ordered the test has a duty to follow up on the results. The anesthesiologist may be requesting

certain tests as a consultant, and has a duty to follow up on an abnormality even if it is unrelated to the immediate anesthesia care [Shadwell v. Craigie, 361 S.C. 492 (Ct. App. 2004) 605 S.E.2d 567]. By eliminating unnecessary tests, not only is liability reduced, but also there can be a focused follow-up on what are clinical rather than spurious abnormalities.

Preanesthesia Consultations

The need for a preoperative consultation may occur when a patient's condition is beyond a physician's knowledge, training or experience. A physician is not expected to know everything about a patient's condition to effectively treat the patient. Therefore, he may seek consultation with other qualified specialists capable of providing the services [Morgan v. Engles, 127 N.W. 2d 382 (1964)]. In the perioperative period, a consultant may be the patient's primary care physician or specialty consultant (e.g., for evaluation of cardiac, pulmonary, endocrine, or neurologic condition), and would reflect the need for assistance in clinically managing the patients' condition.

It is not necessary to consult a specialist when the patient's problem is within the scope of the anesthesiologist's training and expertise unless a consultant's input would clearly result in a significantly more beneficial treatment than what is already being provided [Largess v. Tatem, 291 A.2d 398 (1972)]. In the situation where the anesthesiologist feels inexperienced in treating a potentially serious condition, a physician has a duty to consult a qualified resource. Many of the preoperative "medical clearances" obtained are not considered consultations in the traditional sense, and serve often as data seeking inquiries, that will enable the anesthesiologist to arrive at the proper decision and plan. Nevertheless, if consultation with other specialists is sought, specific indications need to be communicated. Often, there is poor communication between the consultant and surgeon, and the anesthesiologist gets caught in the middle (e.g. cardiologist not aware patient was scheduled for surgery, and plans a cardiac workup on the day of surgery). [Warren v. Med'C Health Grp, Inc., 936 A.2d 733 (DC 2007)].

Anesthesiologist as a Consultant

In the perioperative period the anesthesiologist may seek specialty consultations but may also be considered a specialty consultant. When the anesthesiologist is serving as a consultant, the original provider (e.g., surgeon or primary care physician) remains primarily responsible for the patient's treatment, with the anesthesiologist providing additional information and recommendations. The anesthesiologists may identify other issues during preanesthesia evaluation, which should be communicated to the surgeon and/or primary care physician. In these circumstances, the anesthesiologist's duty as a consultant is limited to the scope of the preanesthesia evaluation, but if made aware of something outside his expertise, should communicate that to the treating physician [White v. Mehta, 0023442/ 2002 (11-16-2007) 2007 NY Slip Op 33866 (U)]. A common example is noting abnormal preoperative laboratory tests that do

not have direct impact on anesthesiologist's recommendations, or identifying new clinical condition of patient beyond the scope of care of an anesthesiologist.

Documentation (Do's and Don'ts)

Accurate documentation is the cornerstone of both good patient care and a good medicolegal defense. In the courtroom, it provides a "medical story" for the jury, and a record for you years after an adverse event. Absence of good record keeping and a description of critical events leave an opening for the plaintiff's lawyer to cast doubt on the quality of your anesthetic care. Altering the preoperative or anesthetic record after an adverse event should never be done. It is inappropriate and it also makes your care suspect. A purposeful addendum that is written clearly after the fact and indicated as such can be appropriate.

Do's

1. Write legibly.
2. Document preoperative discussion of anesthetic risks and benefits with patients. Document patient refusal of any recommended care, such as refusal of regional anesthetic or blood product administration.
3. Sign, time, and date entries in the medical record.
4. Sign and date the anesthetic record.
5. Document any additional patient care monitoring or procedures that you carry out (e.g., eye, face, and arm checks in the prone position at regular intervals).
6. Document fluids administered, blood loss, and urine output at regular intervals as it demonstrates that you were continuously re-evaluating the patient's volume status and making appropriate interventions.
7. Document all medications administered.
8. Document any surgical requests with surgeon name and specific request (e.g., "Dr. Smith requested deliberate hypotension to a systolic blood pressure of 95 mm Hg." "Dr. Jones requested placement of a central venous catheter for hemodynamic monitoring and intravenous access after surgery."). If an adverse event occurs, it may be difficult to recall specifics about cases at a time remote from the event.
9. Document any adverse events in the anesthetic and medical record. Describe pertinent details without speculation; describe course of action and recommended follow-up; describe any other communications with other services, care providers, and family. Documentation in the medical record is essential as the anesthetic record is not reviewed by most non-anesthesiologists. Entries that are made after a critical event should note approximated time entries.
10. Document all patient visits and conversations with family after an adverse event in the medical record and who was present at each conversation.

Don'ts

1. Don't cross out incorrect entries in the medical record. It may be interpreted as covering your tracks. You may place one horizontal line through the incorrect entry leaving it legible, and add the correct information with date, time, and signature. Alternatively, it is preferable to add an addendum elsewhere in the record without altering the original entry.
2. Don't make duplicate copies of the anesthesia record after an adverse event. It may be interpreted as record tampering.
3. Don't admit wrongdoing in the written medical record. Events may be interpreted differently at a later time point when new information from diagnostic tests becomes available. Describe the events as they unfolded. Do not speculate. For example, a patient becomes precipitously hypotensive and suffers a cardiac arrest with anesthetic induction. You assume responsibility in the medical record. However, autopsy later shows that the patient had multivessel coronary artery disease with a 90 percent lesion of the left main coronary artery, demonstrating patient condition as the primary etiology of the adverse event.
4. Don't accuse other services of wrongdoing after an adverse event. Plaintiffs' lawyers benefit from physicians pointing fingers at each other. It makes the whole institution appear substandard.
5. Don't use the term "inadvertent" as it may convey a message of guilt or negligence. "Accidental" is a better term to use (e.g., accidental intrathecal injection).

Vicarious Liability

Vicarious liability refers to liability incurred by supervision of other care providers in a subordinate position. For anesthesiologists, this list would include residents, nurse anesthetists, and nurses from the operating room, the recovery room, and the hospital floor. Although anesthesiologists may not be their employer, there may be a written contract that a member of the department of anesthesiology will supervise them. Furthermore, anyone in a subordinate position who assists anesthesiologists may fall into this category with respect to vicarious liability. Such encounters may occur in the operating room during positioning of the patient, assisting with a procedure, transferring the patient from gurney to bed, and placement of warming devices. In the recovery room, nursing administration of any medication that the anesthesiologist has ordered, monitoring of respiratory status and cardiovascular hemodynamics, and discharge to the intensive care, floor, or home could potentially be argued as vicarious liability for the anesthesiologist. Anesthesiologists are frequently involved in respiratory arrest claims associated with pain management that occur on the floor with inadequate nursing supervision.

The primary source of vicarious liability for anesthesiologists is from supervision of nurse anesthetists, anesthesia assistants, and residents. In order to protect oneself, the intensity of supervision should be guided by the degree of competence exhibited by the resident or nurse anesthetist, as well as their level of training and experience.

There is a wide range of ability among individuals, and the level of supervision should be adjusted accordingly, keeping in mind that appropriate billing requirements must also be met. Situations may be encountered when incompetent individuals may be difficult to dismiss because of institutional policies or political concerns. Careful documentation of their substandard care and / or refusal to follow instructions should be made and sent to the departmental and administrative heads in an attempt to rectify any unsafe situations.

Although the resident or nurse anesthetist and anesthesiologist ideally should agree on an anesthetic plan after discussion of the pertinent issues, the anesthesiologist has the final and ultimate responsibility for the anesthetic care of the patient. Consequently, the anesthesiologist has the final decision-making authority. Reneging on this responsibility for political reasons may lead to adverse events with significant vicarious liability.

As healthcare dollars shrink, the anesthesiologist may find him/herself staffing a larger number of anesthetizing locations. Data on the safety of various staffing ratios have multiple confounding factors that are difficult to control, such as type of case mix, co-existing patient diseases, as well as experience and training of both the anesthesiologist and the resident or nurse anesthetist. Whatever the staffing ratio, the anesthesiologist is ultimately responsible for the care delivered. If the acuity of care demands is too high for staffing multiple rooms, alternative arrangements should be made. The anesthesiologist should be available for critical events and safe management of every case.

Vicarious liability can be minimized by documentation of the discussion of the anesthetic plan with subordinates and documentation of the anesthesiologist's presence in the room at various times throughout the case. Lack of this documentation is a frequent opening used by plaintiffs' lawyers to suggest inadequate supervision of care. Hospital-approved policies for conduct of care of staff in the operating rooms, recovery rooms, and floors should also help the anesthesiologist avoid liability for adverse events not under their direct influence. Generally speaking, each situation will be analyzed to determine the extent of actual control that the supervisor had over the subordinate's care.

WHAT TO DO IN THE EVENT OF A BAD OUTCOME?

Although there is no standard definition for a medical error, commonly accepted definitions include failure of the planned action to be completed as intended, delivery of an inappropriate method of care, and the use of the wrong plan to achieve a goal.²⁹ Medical errors can be classified into slips (failure in the execution of an action, irrespective of whether or not the plan behind it was adequate to reach its objective), lapses (involves memory failure and may only be apparent to the persons who experience them), and mistakes (when a plan proves inadequate – rule-based

mistake and knowledge-based mistake). Examples of medical errors that can occur during the perioperative period include wrong patient, wrong surgery, wrong site, wrong diagnosis, failure to diagnose, retained foreign bodies, and wrong drug and/or dose.³⁰

Disclosure of Medical Errors and Apology

Medical error disclosure, including the decision to incorporate an apology, is a complex, controversial, and challenging issue.³¹ Anesthesiologists are typically uncomfortable with this process since most have little to no formal training in the disclosure of medical errors. There is significant controversy among anesthesiologists, hospitals, and attorneys regarding the routine use of a full disclosure after a medical error.³² For the most part, the controversy regarding full medical error disclosure surrounds the potential medicolegal consequences. There is a concern that full disclosure of a medical error may result in increased litigation, decreased verdict success, and higher plaintiff monetary rewards. Other concerns with full disclosure of medical errors include the potential increased risk for additional parties to be brought into litigation and damaging effects to a physician's career due to loss of reputation and database reporting (e.g. National Practitioner Data Bank).

In contrast, there are several proposed advantages from utilizing a process of full disclosure for medical errors.³³ Providing a full explanation of the medical error, and offering a sincere apology may counteract the tendencies for the patient or family to file litigation.³⁴ Thus, patients may be less inclined to initiate litigation due to a medical error, particularly if a positive patient-physician relationship exists. Utilizing a full disclosure of medical errors is one component of maintaining this patient-physician relationship. A transparent and complete disclosure may encourage out-of-court settlements, prompt resolution of the incident, and decreased litigation rates against hospitals and physicians. Anesthesiologists can also have peace of mind from implementing a transparent appearance of their practice to the patient, family, and to themselves.

Many would argue that the truth should be told even though it is uncomfortable and has possible legal implications. In contrast to saying "I made a mistake," which is an admission of guilt, saying "I'm sorry" that this unfortunate event occurred is a very appropriate and compassionate comment. Apologizing for the event occurring is not equivalent to the admission of negligence or guilt. There are no recommendations at this time regarding the use of an apology or admitting fault such as "I'm sorry this occurred" as opposed to saying "I made a mistake". The anesthesiologist should seek advice from their risk management department and/or malpractice carrier regarding these options prior to discussions with the patient or family. Many states are adopting "apology laws" that are designed to encourage healthcare providers to apologize after a medical error; these laws are designed with the intent to not allow the apology to be admissible as evidence.^{35,36} It is important to become familiar with individual state's legislation and limitations regarding "apology laws".

In October 2007, there were 25 states plus District of Columbia requiring the mandatory reporting of medical errors to administrative organizations.³⁷ The Joint Commission (previously JCAHO) currently requires all hospitals to develop comprehensive policies regarding patient safety that includes the disclosure of "unanticipated outcomes" to patients or families.

It is important to realize that a bad clinical outcome may not always result from a medical error. In fact, in most instances it is usually an expected complication from the patient's underlying medical condition or procedure. Therefore, use of full disclosure for a medical error should only be utilized when the anesthesiologist strongly feels that a medical error has occurred. It is always appropriate to have full disclosure of a bad clinical outcome not related to a medical error.

Disclosure of a medical error in absence of a bad outcome is extremely controversial. Some experts would argue if no harm is detectable then it is unnecessary to disclose. However, the opposite argument is that it is equally important to disclose a medical error if no detectable morbidity or damage has occurred.

Providing a full disclosure after a medical error is a comprehensive process that requires appropriate preparation, coordination, and acquisition of several resources.³⁸ A discussion with the patient and family should be arranged in a timely manner. This discussion should be at an appropriate educational level and in the primary language of the patient and family. Consider briefly discussing the medical error with the other involved parties prior to speaking with the patient and family. Ask the other involved parties their opinion regarding the error; you may be very surprised by what they think occurred or what they observed.

Plan what you're going to tell the patient and family in advance. Discuss briefly with the other involved parties (e.g., surgeon, anesthesiologist, nurse, and pharmacist) what you're going to tell the patient or family. Consultation with the appropriate risk management department may also be beneficial.³⁹ Make every effort to have all involved parties at the time of the initial disclosure. This will avoid the patient and family hearing multiple and possibly different explanations; this can result in decreased credibility for all involved parties.

During disclosure of a medical error, a compassionate discussion should occur in a private environment. Social workers, clergy, family members, and language interpreters should all be offered to be present at the discussion. Take the additional time to completely explain the conditions under which the medical error occurred. Inform the patient and family what you currently know and don't know regarding the medical error; many details may still not be well established at this time. It is common after a significant adverse event to go speak to the patient or family without complete knowledge of all details or sequence of events. This is an acceptable practice but future conversations with the patient or family may need to be modified as additional information becomes available.

Describe what therapy was completed and what future therapies are planned. Discuss only objective findings and reasonable alternative explanations for the medical error. An important part of the discussion should include the process to

investigate the medical error and implement performance improvement initiatives to prevent recurrence of this medical error to others. It is not appropriate to assign blame to others; this could be interpreted as admission of guilt to the patient or family. Additional discussions should be anticipated to occur; these should focus on coordination of care, answering questions, and maintaining a good relationship with the patient and family.

TABLE 1: SUMMARY OF THE KEY COMPONENTS FOR AN EFFECTIVE DISCLOSURE OF A MEDICAL ERROR INCLUDE:

Preparation

- Review the event with the involved parties
- Plan your discussion with patient or family in advance
- Select a quiet and private location for the discussion
- Offer language interpreters, social workers, and clergy to be present
- Have all involved parties at the initial disclosure

Delivery

- Deliver a compassionate and unhurried explanation
- Explain the conditions under which the medical error occurred
- Discuss objectively what you know and don't know
- Verify that the patient and family understand your explanation
- Describe the previous, current, and future therapies
- Describe the process for investigation and performance improvement
- Consider incorporating an apology for confirmed medical errors

Follow-up

- Provide frequent updates to the patient and family
 - Make yourself easily accessible to the patient and family
 - Facilitate discussions between risk management, the hospital, and the patient or family
-

Despite a transparent and compassionate approach, some patients and family members may specifically request or develop behaviors that imply further communication with them would not be suggested. If such a situation arises, the anesthesiologist may first wish to verify that they prefer no further contact. If this is indeed their position, it is recommended for you to abide by their request. However, the family may be amendable to another colleague acting as the anesthesiology representative. The service chief or department chairs are individuals recommended for this responsibility. These individuals may already have knowledge of the event and may have experience in handling similar situations.

The approach to billing for professional services after a medical error has occurred is complex. Most experts would recommend billing for professional services regardless if a medical error has occurred. Waiving the professional services fee could be interpreted as an admission of guilt. Furthermore, the bill would most likely need to be completely waived since many insurance carriers prohibit waiving the patient's co-pay and only billing the insurance carrier. However, the opposite argument is by sending a bill while the patient or family remains dissatisfied about the incident could now persuade them to initiate litigation. Anesthesiologists only control the professional fee for their services; many other additional fees may be generated from the hospital and other physicians. A discussion with the hospital attorney and the risk management department for the anesthesiologist should occur on a case-by-case basis to develop the most effective billing and medical-legal strategy.

Management Of Communications and Documentation After An Adverse Event

Of primary importance in the prevention of malpractice suits after a bad outcome is management of internal and external communications (both written and verbal) regarding the adverse event. All coworkers involved in the initial event (e.g., surgeons, nurses, perioperative support staff, and consultants) should review the circumstances and identify the key elements of the event. It is essential that the description of the event is clear, concise and non-conflicting; indeed, this one step may forestall many negative outcomes from the adverse event, not the least of which is actual litigation. Above all, the documentation of the event should not contain conjecture, speculation, or opinion, especially when complete details and causes may not be known immediately after the event. This process cannot be overemphasized.

This type of concise and immediate communication between the anesthesiologist and/or anesthesia care team, the surgeon and surgical assistants, perioperative nursing, and all adjunct personnel has proven beneficial. Such communication is intended to gather correct information and ensure thorough documentation; it should include the nature of the event, the steps taken to diagnose and treat the event, and the specific time course of these actions. In no way should this suggest collusion or falsifying of events.

Two principles to keep in mind during all communication after a bad outcome are to tell the complete truth and to avoid conflicting narratives whenever possible, especially in discussions that are discoverable, (e.g. not under the aegis of Quality Improvement). A “he said, she said” chart war only leaves casualties and feeds the pockets of lawyers. “Buffing the chart” may make the actions during the event seem more defensible but does little to protect against conflicting testimony from colleagues.

Since the anesthesia record often does not offer much space to elaborate on details, consider making a summary note of the event for the medical record. An immediate summary of the adverse event and recovery period can clarify confusing or absent charting elsewhere and may provide a defense against negligence and malpractice. The summary should re-identify the key elements of the adverse event and verify the

facts and times therein that are recorded in the anesthesia record. This should include the event itself and the recovery period after the event until primary care of the patient is transferred to another physician. Again, the medical record documentation should avoid “chart wars,” assigning blame, and speculating, since these can be extremely detrimental in the court of law. These notes should be centered on facts and not speculation; it is appropriate to include the differential diagnosis to show what was considered and the actions taken, but should avoid “pointing fingers,” especially when etiologies are unclear.

After an adverse event, appropriate event-reporting procedures including notification to the quality improvement department are necessary. However, care must be taken with respect to communications with colleagues outside of the official review system. Such “curbside consults” are natural but risky, as they are not only discoverable (i.e. not protected) but can be construed as admissions of guilt, especially when quoted out of context. It is not unusual for plaintiffs to use colleagues’ comments against defendants. Indeed, it is not unheard of for “colleagues” to be used as character “assassins,” confounders of “facts,” and even opposing expert witnesses.

Although it may seem obvious, it is necessary to emphasize that the patient should not be abandoned after an adverse event. Surprisingly, this occurs frequently. Patients must be followed, and consultations and tests must be reviewed. These post-event actions show ongoing concern and responsibility, and may reduce the likelihood of litigation resulting from patients and/or families who might feel abandoned or mistreated.

The patients and/or family should be informed about the adverse event as soon as possible. This is invaluable in reassuring the patient and the family that optimal care is being provided. These communications should be as simple as possible and free from speculation. The information would include the timing of events, the actions taken, the current status, and expected course as well as what is currently known and unknown about the cause of the adverse event. It is imperative that these communications are documented in patient’s chart.

Part of post-event communication management includes recognition of any malpractice litigation “prodromes” which may signal an imminent lawsuit. Written complaints, demands for money, threatens of malpractice suit or requests from patients’ attorney for medical records must be taken seriously, but do not constitute a malpractice suit and may be merely fact-finding. It is necessary to send copies of all such correspondence to the risk management department and the malpractice insurance carrier. Many insurance carriers take a proactive stance to prevent events from progressing to a full-blown litigation. It is important to comply with requests from attorneys, ensuring that all paperwork regarding the release of records is in order. Do not modify the records in any way or write a cover letter. Nevertheless, any further communication should be done through an attorney, who assures that proper releases and forms are signed to prevent further litigation.

The final step in the communication management process is simple but vital, and includes creating a personal file for the adverse event that contains personal notes,

copies of all relevant medical records, and communications. Although this file is ‘discoverable,’ it helps prevent potential confusion due to illegibility or incompleteness caused by lost records.

WHAT TO DO WHEN SUED?

Stages of a Lawsuit

A lawsuit begins when the plaintiff’s attorney notifies an intention to sue or files a complaint in the courthouse in the county where the medical event occurred. In some States, the process server is an officer of the court or deputy sheriff. The complaint will include the allegations and a demand for relief. The complaint might be stated in general terms or be more specific. It may be subject to penalty of perjury. The notice of intent and complaint will both toll the statute of limitations. The limitations period may be short or long depending upon the state in which the event occurred. It may be lengthened under certain circumstances, even by you being out of the state at any time during the limitation period. For example, there is such a provision in California law (See California Code of Civil Procedure [§ 351](#)). The notice of intention will allow all involved to possibly prevent any obvious unnecessary further events from occurring.

Due process requires that once proceedings in the court have been instituted, notification by a summons and having an opportunity to be heard must be provided to you. Normally you will be served with the summons and copy of the complaint personally by a registered process server or a sheriff’s deputy. If this is difficult you can be served by substitute, and as the difficulty in service increases the less direct the service may become. It may in certain situations even be accomplished merely by publication or by notifying a state official. You may be notified even if you reside in another state at the time.

The summons will inform you of the time period in which you must answer before a default judgment can be entered against you. Normally a default judgment can be set aside but this is expensive, and the judgment may be upheld in certain circumstances. Your answer will require admissions or denials and be required to be general or more specific, and under penalty of perjury depending on the format of the complaint and the state rules. Your answer might also include affirmative defenses such as the application of the statute of limitations. After the initial notification by summons (or an appearance by you at the court), further notification will be merely depositing a letter in a mailbox, or in an “emergency” leaving a message by telephone.

There may be a case management conference with the judge to settle the initial differences, make a plan regarding discovery and trial dates, and agreements regarding dispute resolution procedures. Before the trial phase begins, either party may ask the judge to dismiss portions of the other’s papers and even make a judgment against either party if no material facts are in dispute. Usually the latter will occur after discovery of all the facts and clarifications of issues has occurred. One of the purposes of discovery

may be to harass the defendant to determine if he/she may be a good/bad witness. There are many discovery devices.

The three primary aspects of the litigation are written interrogatories (a series of questions that are to be answered under penalty of perjury), demands for copies of documents, and oral depositions. Interrogatories and document demands precede depositions as the latter are much more expensive and only one is allowed and preparation is critical. The entire discovery process is designed to be accomplished between the parties, and if the judge is asked to be involved (such as for answering too ambiguously or cryptically or invalid refusals) sanctions will be imposed on the party at fault.

Of note, letters from patients demanding money or threatening a malpractice lawsuit, or requests from legal firms for medical records do not constitute a malpractice lawsuit, although such actions must be taken seriously and may necessitate notification of the malpractice carrier.

Interactions with Insurance Carriers and Defense Attorneys

Insurance carriers must be notified immediately after receiving the complaint. The insurance company will hire an attorney to represent both it and you. The attorney owes fiduciary duties to both clients. The attorney must provide competent representation (ABA Model Rule 1.1), confidentiality, and loyalty. The fiduciary duty of loyalty continues after the termination of the relationship. If there is a conflict of interest, such as denial of coverage, the insurer may be required to provide independent counsel to you. You also have the absolute right to terminate lawyer services at any time and for any reason. The insurance carrier may be requested to provide another attorney or you may consider retaining private counsel. The lawyer may not withdraw representation without permission from the court. Examples of permitted reasons include: you insisting on a nonmeritorious defense, seeking to pursue an illegal course of conduct, insisting the attorney acts unethically, or are unreasonably difficult to work with.

Your attorney and you would first prepare an answer to the complaint, which contains the facts and allegations. During this process, it may be necessary to be frank and candid with your attorney, and sometimes educate them regarding the medical aspects of the case. Your attorney has a duty to communicate with you. He must keep you reasonably well informed and respond promptly to reasonable status inquiries. There is a special duty for the attorney to communicate settlement offers. The attorney has implied authority as to procedural matters, but the client has the right to make ultimate decisions affecting the outcome of the case. But, your insurer has authority to settle if there is sufficient coverage and there is no reservation of rights, unless the policy states otherwise. This might be a reason to obtain alternate representation. A separate attorney may be invaluable if the estimated damage settlement is greater than the limits of the insurance coverage, the physician may be personally liable for the difference. Similarly, if the lawsuit may result in limited or revoked practice privileges, a private counsel may be retained.

Payment on any medical malpractice judgment or settlement, regardless of the amount, will trigger a requirement that the payment and circumstances be reported to HHS and the state medical licensing board.⁴⁰ The information is kept in the National Practitioner Data Bank available only to licensing agencies and health care practitioners, but it may be accessible to others under the Freedom of Information Act. Your state, for example, may require disclosure to the public of this information and an investigation of your competence. You may be required to report it on any application for privileges, employment, insurance, or provider status.

TABLE 2: STEPS TO BE TAKEN WHEN YOU RECEIVE A NOTICE OF LAWSUIT

1. Notify your insurance carrier.
 2. Do not discuss the case with anyone, including colleagues who may have been involved, operating room personnel or friends.
 3. Gather together all pertinent records, including a copy of the anesthetic record, billing statements and correspondence concerning the case.
 4. Dictate and make notes recording all events recalled about the case. It may be necessary to review the medical record. Some attorneys will recommend that physicians establish a separate file for all documents pertinent to the case, making certain that the file is marked confidential.
 5. Do not alter any records.
 6. Cooperate fully with the attorney provided by the insurer in answering the complaint.
 7. Be involved in your defense.
-

Expert Witness Selection and Interaction

A physician or a representative, who is employed by the insurer, will review the records and provide an initial impression with regards to the allegations of injury and breach of standard of care. The records may then be submitted for review by outside expert reviewers, who will provide verbal input with regards to the standard of care and the “defensibility” of the case. Based on the input, a decision may be made whether or not to settle the claim. If it is decided to defend the suit, the reviewer may be asked to be an expert witness. Alternatively, the defense lawyer may suggest the name(s) of the defense expert witness based on prior experience and work. Expert witnesses from other specialties may be involved if the claim involves events and/or physicians of different specialties.

Insurance carriers, risk managers, plaintiff, and defense attorneys may obtain information on past opinions and testimonies of expert witnesses by using several resources such as LexisNexis, [<https://litigator.lexisnexis.com/Litigator.aspx?page=Investigation/Investigation.aspx&ap1=6&ap2=4>] and Westlaw [www.westlaw.com]. However, these sites may charge some fees

for the information. These are large searchable databases of public records, opinions, forms, legal matters, news, and business information. In addition to the database, products and services are provided to an eclectic group of professionals including but not restricted to legal, risk management, corporate, government, law enforcement, academics, and insurance carriers. Public documents (as well as non public documents) including past testimonies of expert witnesses may be found in these databases.

Although defendant physician is informed of the progress, he/she must remain involved in their defense including reviewing the responses to allegations and interrogatories that suggest breaches of standard of care and expert witness opinions. In addition, physicians should be willing to educate their attorneys about the medical facts of the case, if necessary. Importantly, the defendant physician should not have any contact with the expert witnesses so as maintain the impartiality, objectivity, and credibility of the expert witness and avoid the perception of bias.

Deposition

Depositions are a **pre-trial form of discovery** that provides, through sworn testimony, advance notice of all of the significant clinical evidence and conclusions that each witness in a malpractice action expects to offer at trial. But it also offers legal counsel on both sides the opportunity to analyze and probe the deponents themselves in order to determine whether and how to minimize and defeat the positions taken by a deponent to the advantage of the opposition lawyer. Therefore, the deposition process for the defendant anesthesiologist is, by its intent, **“an adversarial process”** in the pursuit of a claim against this physician. Pursuit of this claim will involve proving to a **“degree of reasonable medical certainty”**, that a breach of the standards of care occurred involving the defendant anesthesiologist that caused injury to the patient sufficient enough to claim money damages. The defendant must understand that it is only necessary for the plaintiff to prove to a judge or jury that a significant breach **“more likely than not”** occurred. **“More likely than not”** is interpreted to mean a greater than a 50 percent probability that this breach is the cause of the patient’s injury and that the injury would not have occurred but for the breach. The expert medical witness anesthesiologist for the plaintiff, via prior declarations and testimony, will have testified to specific breaches of the standards of care supporting the plaintiffs’ claims. Therefore, the objectives of the defendant anesthesiologist in deposition are twofold:

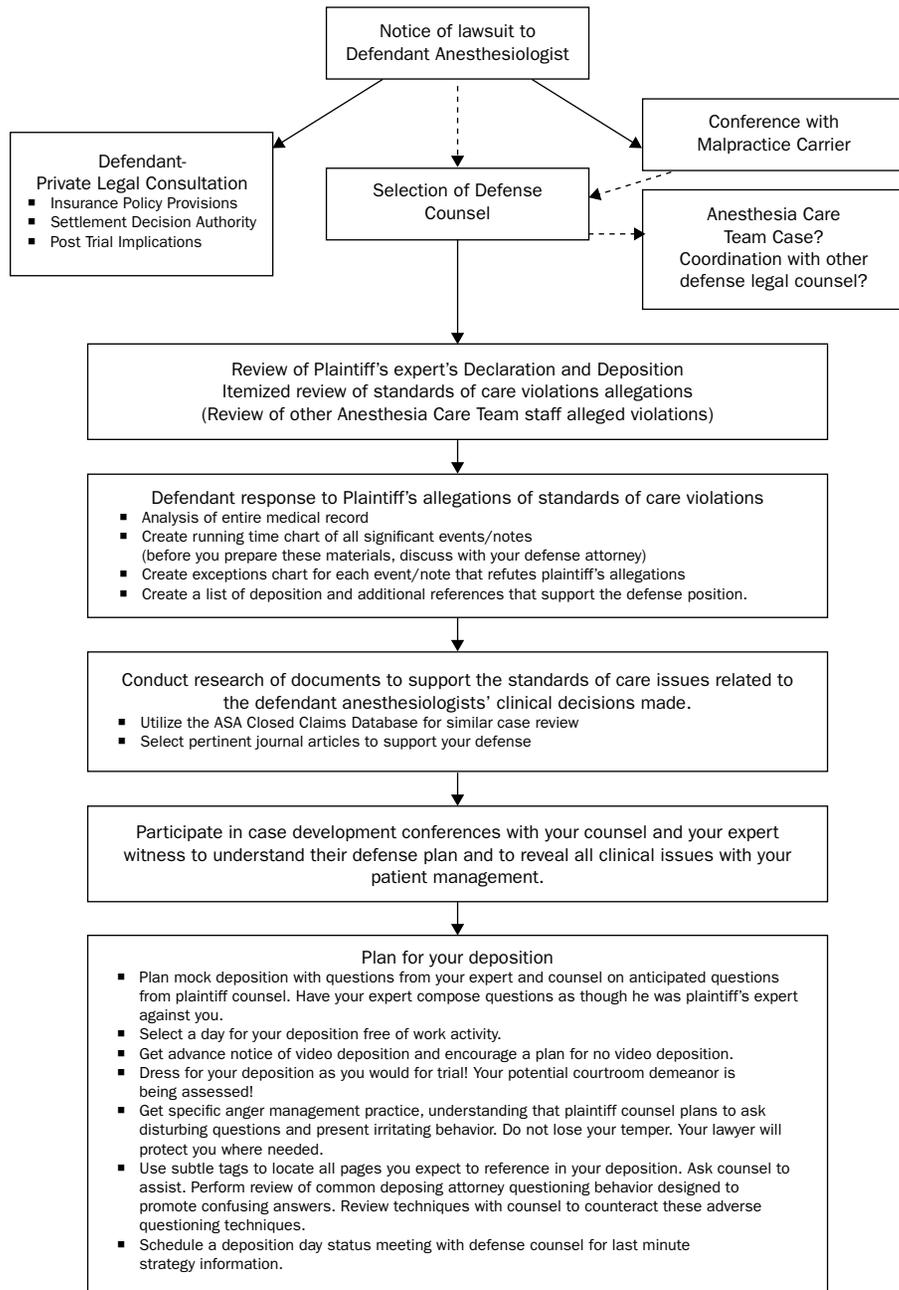
1. To offer clinical and evidence-based rebuttal to defend against each breach of the standards of care alleged by the plaintiff’s expert.
2. To offer new evidence and clinical analysis that rebuts the allegations of plaintiffs’ expert.

If the defendant anesthesiologist, working with his defense expert and legal team can offer sufficient evidence and reliable conclusions to rebut the allegations of the plaintiffs’ position, no significant breaches of the standards of care will be found and the defense will win the case.

Another concept of the deposition is the reality that factors other than evidence affect the decision making of the jury. The best quote heard to describe this concept is that **“a trial is theater”**. It is not only important to be correct in the position of proving that a breach of the standards did not occur, but it must be done by convincing the jury that the defense position is the most credible. The defendant anesthesiologists’ credibility may be as important as the evidence itself to the jury. Once credibility is lost to the jury, it cannot be recovered. Attitude, appearance and appropriate testimony are the watchwords of defense testimony. Because of the importance of the above concepts, and the fact that the deposition is given under oath, the deposition is as important as the trial in terms of preparation and performance.

Observing that only two in ten lawsuits progress to the trial by jury, a good performance at deposition could result in having the case dropped before trial. Also important here is that the malpractice insurance firm for the defendant will also be closely assessing the nature of the defense deposition. They will also be judging the quality and specifics of the defense deposition in assessing whether to recommend settlement or to continue to trial. Evaluation of the specific terms and conditions of the various malpractice coverage provisions allow for changing financial exposure to the defendant anesthesiologist if defense conclusions regarding settlement or continuation to trial are at issue. So, a vigorous defendant anesthesiologist deposition is also important for this reason. Figure 1 summarizes the development of the defense anesthesiologist from notice of suit through the deposition. It is a general guide for the anesthesiologist to be aware of all the steps in the process and to participate to the maximum extent possible in his own defense. An important thing to remember is to be careful about preparing notes or charts. Before preparing any such materials, discuss with the defense attorney because they may be subject to discovery under state law and the attorney should consent to their preparation. The intent may be to produce such materials, but it may not be the intent. If the latter, there may be a way to prepare them in a manner to ensure they are not discoverable.

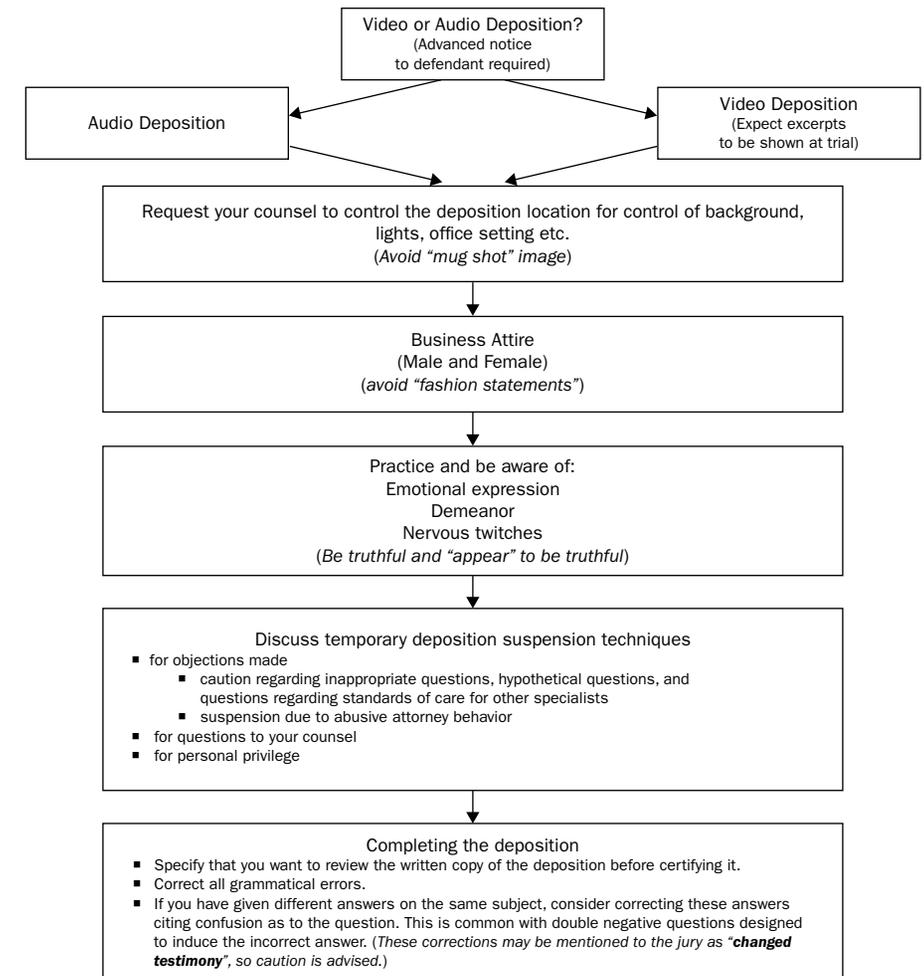
FIGURE 1: MEDICAL MALPRACTICE DEFENSE ALGORITHM - ANESTHESIOLOGY



Defendant Anesthesiologist Deposition Management

The defense anesthesiologist's deposition is important enough that all details under the defense control should be planned. Figure 2 summarizes each of these details that can be huge, unsettling issues at deposition if not managed carefully. The defendant physician is under great stress, and failure to manage these issues can be detrimental to the process even though they may have little to do with the real case issues. Attention to these details can allow for the best possible presentation of the defense position.

FIGURE 2: DEPOSITION MANAGEMENT CHART FOR ANESTHESIOLOGY DEFENDANT



Mediation, Arbitration, and Settlement

Most courts encourage or require alternative dispute resolution. The patient may be required to arbitrate by previous agreement. This must be a true agreement, but will cover future events and may even be used retroactively to agreement date. See [Coon v Nicola \(1993\) 17 CA4th 1225, 21 CR2d 846](#). Mediation will involve a neutral mediator agreed upon by the parties. The court will supply a list of acceptable mediators. It is helpful that the mediator is experienced in litigating the type of case involved. The mediator will, either with the parties in the same room or separate, attempt to come to a settlement. All writings and discussions are confidential. The settlement, if any, becomes a contract and will be binding. Judicial arbitration is similar to a trial and the award will become binding unless one party requests a trial. A mandatory settlement conference will be before a judge prior to trial. If the case is tried in a state with limitations on awards this might influence both parties' lawyers to settle as the plaintiff's will not want to pursue an expensive case with little potential payout, and the defense will not want to be potentially liable for a large award.

Court Appearance

If a settlement is not reached, usually when each side believes that its case is strong, jury trial will occur. The jurisdiction in which the case is tried and the composition of the jury may impact the eventual outcome of the trial. A number of other factors, including severity of the adverse outcome as well as the appearance and professional behavior of the anesthesiologist and his/her ability to communicate, may also influence the outcome of the trial. The defendant anesthesiologist must be present during the trial even though he/she is not testifying.

The recommendations for deposition also apply to the court appearance. The anesthesiologist should review the discovery deposition prior to the court appearance. It is critical that the anesthesiologist does not use complex medical terms and should explain the answers in lay terms so that the jury will understand. The anesthesiologist must appear confident without seeming pompous and condescending.

What to do after the case is closed?

Once the case is closed and if you believe that there was expert testimony that did not comply with the American Society of Anesthesiologists (ASA) Guidelines for Expert Witness Qualifications and Testimony (Guidelines), you may file a complaint with ASA for evaluation by the Committee on Expert Witness Testimony Review. The ASA Guidelines can be found on the ASA website.

COUNTERSUITS

Although there is the possibility of pursuing a countersuit, the likelihood of success is exceedingly small. Successful countersuits for malicious prosecution depend upon the ability of the physician to prove that there was a malicious intent involved in filing the lawsuit. This is very difficult to prove.

"Abuse of process" lawsuits require proof of an ulterior motive in the filing of the suit as well as a willful, improper act in the use of process. Defamation suits are unlikely to be successful because attorneys are absolutely privileged to make defamatory remarks preliminary to or as part of a judicial proceeding as long as the remarks have some relation to the proceedings.

The greatest problem in pursuing this course of action is that because no countersuit has been successful at an appellate level, few attorneys will agree to file a suit on a contingent fee basis. What this means in very practical terms is that the physician will probably pay a substantial retainer out-of-pocket to pursue a course of action which is very unlikely to be successful.

PSYCHOLOGICAL IMPACT OF LAWSUITS

Personal Impact

For most physicians, medical malpractice litigation is a life trauma that can have a significant personal and emotional impact.⁴¹⁻⁴⁴ As with many psychologically stressful events, the individual proceeds through the five stages of grieving as described by Elisabeth Kubler-Ross: denial, anger, bargaining, depression and acceptance.^{45,46} The psychological consequences, however, can persist long after the litigation process has concluded.^{41,47,48} Afflictions following the process include depression, adjustment disorder, post-traumatic stress disorder and substance abuse.

Professional Impact

The legal process creates a challenge to physicians' professional identities and practices.^{41,49,50} Physicians share a number of common personality traits. Beneficial traits include diligence, compassion and perfectionism. However, additional traits include a propensity for self-doubt and guilt.^{47,51} Following allegations of wrongdoing or malpractice, these later traits can generate substantial psychological distress with resultant changes in the physician's practice. These changes include reevaluation of professional motivation and inherent patient mistrust. In one study, physicians reported that following litigation they were "likely to stop seeing certain types of patients, think of retiring early and discourage their children from entering medicine".⁵²

Social Impact

With impending or ongoing litigation, physicians often isolate themselves and their families from the issue. Paradoxically, this behavior often results in unintended consequences. Marital relationships are commonly compromised by malpractice stress.⁵³ Although not immediately obvious, the physician's spouse experiences similar psychosocial stresses to the physician. These include loss, isolation, vulnerability and social awkwardness.⁵⁴ Parental relationships are also negatively impacted. Children may be disturbed and confused by peer allegations of parental wrongdoing with resultant feelings of deception or shame.

Sound strategies for coping with litigation will yield optimal personal and professional results. Three principle areas of focus are social support, mental health and physical health.^{47,55} Social support is the first major area of focus. During litigation, physicians are appropriately advised not to discuss the “facts regarding the case” for fear of compromising their legal defense. Social support, however, involves addressing the emotional impact of the situation while maintaining factual confidentiality.^{42,47,56} Sources of assistance can include family, trusted colleagues, mental health professionals, attorneys, risk managers or malpractice carriers. As discussed, immediate family members are involved despite concerted efforts to “protect” them. Incorporating familial support and understanding regarding the emotional aspects, while maintaining legal confidentiality, is advantageous for all parties involved.

Mental health, the second major area of focus, involves expert help from both the medical and legal community. From a medical perspective, consider establishing care with a mental health professional. While a defense verdict is personally and professionally vindicating, this outcome may not prevent the long-term psychological impact imposed by the litigation process.⁴⁴ The anesthesiologist benefits greatly from addressing and resolving the psychological conflicts associated with the litigation process.⁴⁸ Further, optimal psychological tools for managing the accompanying stress potentially improve the litigation outcome.⁵⁶ This relatively small time commitment will yield disproportionately large dividends. Of interest, some larger practice organizations require psychological counseling for their physicians involved in litigation. From a legal perspective, allow your attorney and malpractice provider to be a resource.⁴² Learn about the legal process, participate in your defense and establish a modicum of control in this difficult situation. This collegial effort with your legal team is both beneficial to your mental health and to your legal defense.

Physical health, the final area for consideration, is commonly neglected. Mental and physical health is symbiotic. In this regard, allow regular scheduled time for personal issues and exercise. Common physical manifestations associated with litigation include anxiety and insomnia. Avoid the temptation to self-prescribe sleep aids, anxiolytics or any other medications. Unfortunately, physicians can and have become victims of self-medicating and drug misuse.⁵⁷ Treat yourself as you would your patients and obtain professional support.

SPECIAL CONSIDERATIONS

Professional Liability Insurance

The majority of physicians in practice today carry medical malpractice insurance to protect their personal assets in case a lawsuit is initiated against them. Malpractice policies cover both the expenses incurred in the defense of a lawsuit as well as any damages that are awarded up to the policy limits. The policy limits are usually quoted as a pair of numbers, i.e. \$1,000,000/3,000,000 which indicates that expenses and losses are covered up to \$1,000,000 per claim and up to \$3,000,000 for all claims over the policy year.

Historically, the type of malpractice insurance offered was an “**occurrence**” policy. This type of insurance provides policy limit **coverage for claims arising from care delivered in the year the policy is in effect, irrespective of the year in which the claim is reported**. Consider this example: If a physician is insured by Company ABC for the year 2007 and an incident occurs in 2007, but a lawsuit is not brought until 2009 (after the physician retires or purchases insurance from a different company), the practitioner will be covered by Company ABC. The occurrence policy provides the most comprehensive protection, but tends to be the most expensive. In determining insurance premium prices, insurers rely on actuarial predictions of the likelihood of a claim being filed as well as how much a claim will likely cost, both in eventual loss and in defense expenses. Medical malpractice claims can take in excess of five years to resolve. Given the lag time between policy purchase and claim reporting and payment, it is very difficult for the insurer to adequately price coverage.

In an attempt to better manage cost and expenses, many insurers providing medical malpractice insurance today issue only “**claims made**” policies. This type of policy provides policy limit **coverage for claims reported during the year the policy is in effect**. Consider the above example again. The physician is insured by Company ABC for the year 2007 and an incident occurs in 2007, but a lawsuit is not initiated until 2009 (after the practitioner retires or purchases insurance from a different company). In this scenario, the physician would not be covered by Company ABC because the claim arose after the insured year. To fill this gap in coverage, a practitioner must purchase a “tail” or extension of the policy from Company ABC to make sure that malpractice insurance will be in effect to pay for possible future losses and expenses. From the insurance company’s perspective, predicting expenses only for cases it is aware of at the close of the year becomes more manageable. Claims made policies may be less expensive, but to ensure continuing protection, purchase of costly tail coverage is required whenever a physician with this type of coverage changes insurance carriers or stops practicing. Of note, some carriers will still write occurrence policies.

Very recently, “**claims paid**” policies have been made available. This uncommon type of policy provides policy limit **coverage only for claims paid during the year the policy is in effect**. These policies are attractive to physicians as they

generally cost less than occurrence or claims made policies during initial years, but premiums are predicted to rise substantially in subsequent years. The industry has little experience with this type of policy and many questions exist with respect to availability of tail coverage.

In some states, coverage in excess of primary policy limits is available, usually in the amount of \$1,000,000/3,000,000 bringing the physician's total coverage to \$2,000,000/\$6,000,000. This additional or second layer of coverage may be purchased by the individual physician or may be funded by some states or healthcare organizations, usually contingent upon completion of risk management education.

Insurance coverage can be purchased from a variety of business entities: commercial insurance companies, physician owned and operated insurance companies, the federal government, large healthcare organizations or Risk Retention Groups (RRGs). It is very important to understand the differences in the coverage provided by these entities. Some companies require a physician's consent to settle a claim, while others may have the interest of the organization as a primary focus as opposed to that of the individual physician. Should an entity feel it is in its best interest to settle a case rather than proceed to trial, and damages are awarded to a plaintiff on behalf of the physician, the action will be reported to the National Practitioner Data Bank. Some entities may have assessable policies. This allows an insurer to assess a policyholder an additional premium if losses exceed revenue to make up the differences.

Medical malpractice insurance is the type of professional liability coverage with which physicians are most familiar. As more physicians assume leadership responsibilities within their practices, healthcare organizations or medical staffs, they may encounter non-clinical liability exposure that will not be covered by traditional medical malpractice policies. Errors and Omissions (E&O) policies offer protection for claims against an entity as a result of administrative mismanagement, while Directors and Officers (D&O) policies provide coverage both for entities (where liability may arise secondary to governance issues) as well as for individual officers and board members.

Obtaining appropriate professional liability coverage is a critical decision for physicians; research regarding coverage offered in the geographic area of practice is strongly encouraged.

Special Considerations For Teaching Programs

Special liability considerations apply to residents and fellows, anesthesiologists who work with trainees, and those who serve in leadership positions of educational programs and/or clinical systems. Courts expect the same standard of care to be provided to patients regardless of who delivers it.⁵⁸ Clinical and educational policies and procedures should be properly structured and followed. Trainees should seek supervision and direction and appropriate attending physicians and professionals should provide it.

There are approximately 260 anesthesiology residency/fellowship programs in the United States accredited by the Accreditation Council for Graduate Medical Education (ACGME). Residents and fellows in accredited programs are employed by an accredited sponsoring institution, which is usually a hospital and its affiliated training sites, but may occasionally be a medical school. Depending upon state law, residents and fellows must possess a conditional or full license to practice medicine, and may face personal malpractice risk for providing substandard care. In general, there are no concessions provided to accommodate Graduate Medical Education (GME). Although there are state-to-state variations, residents and fellows should anticipate being held to a standard of care consistent with that expected of an average attending physician in their subspecialty area. A notable exception is Pennsylvania State, which allows for an intermediate standard of care. Any payment for a claim made against an attending or resident/fellow physician must be reported to the National Practitioner Data Bank, by federal law.

These considerations are particularly important to attending anesthesiologists, since there is frequent interaction with residents and fellows in other medical and surgical subspecialties. In a large study of claims in the Northeast, residents and fellows in surgical specialties were more likely to be named in a claim or suit, and the operating room and recovery rooms were the major locations for lawsuits.⁵⁹ The claims in these cases were related to issues involving clinical judgment in assessing and treating patients, communication with other providers and with the patient and family, documentation and technical skill in performing procedures.

Physicians who serve in leadership positions, as residency or fellowship program directors or as chairs/chiefs of clinical services, face risks associated with these positions. In *Driscoll v Stucker* [2005 Supreme Court of Louisiana No. 04-C-0589], the program director withdrew his recommendation for board eligibility based upon third-hand information received after a resident had successfully graduated from a program, and did not provide this letter to the resident. It was determined that the program director was *personally* liable because he acted outside of his constitutional and contractual obligations and violated the rights of the resident to due process. On appeal, the Supreme Court of Louisiana reversed the judgment of the lower court as to personal liability, but affirmed the judgment against the sponsoring institution.

In *Kadlec Medical Center v. Lakeview Anesthesia Associates* [United States Court of Appeals 2008 No. 06-30745], the court recognized a cause of action for misrepresentation and negligence for failing to disclose information honestly and accurately about a former employee. An anesthesiologist under the influence of narcotics acted negligently, resulting in severe brain damage to a patient undergoing a (10-minute) post-partum tubal ligation. Upon investigation by the hospital, it was discovered that the anesthesiologist was fired for being impaired and for being a threat to patient safety, by his former employer. Two of his anesthesiologist colleagues wrote reference letters calling him "excellent" and recommending him for a job, despite the fact that they had signed the termination letter, which stated that his impairment put

patients at significant risk. The hospital and the injured patient's family successfully sued for millions of dollars in damages for failing to disclose. Malpractice insurance does not cover these situations.

The ACGME requires that the program director provide a final evaluation for residents and fellows upon completion of the program. This should be complete and accurate, and be based on existing evaluations, examinations and supporting documentation. Reports to specialty boards, licensing bodies or hospitals regarding resident/fellow performance should be based upon the final letter of evaluation. Residents and fellows should be informed by the program, at the beginning of residency or fellowship, that information from evaluations is taken together and is used for the final summary evaluation. In addition, as required by the ACGME, residents should be provided with policies and procedures for grievance and due process for addressing academic and other disciplinary actions.

Institutions must follow their own GME policies and procedures. In *Siebe v University of Cincinnati* [Ohio Supreme Court, Court of Claims (October 29 2001) Docket number 96-05467] an anesthesia resident supervised a student nurse anesthetist in placement of a central venous line, resulting in subclavian artery laceration, hemothorax, cardiac arrest and death. The court determined that the hospital breached its duty of care by violating its own policy of requiring an attending anesthesiologist to personally place or supervise placement of a central venous line.

The ACGME requires that "Liability insurance be provided to residents for the duration of training. Such coverage must provide legal defense and protection against awards from claims reported to or filed after the completion of GME if the alleged acts or omissions of the residents are within the scope of the education program. The coverage to be provided should be consistent with the institution's coverage for other medical professional practitioners. Each institution must provide current residents and applicants for residency with the details of the institution's professional liability coverage for residents."

Residents and fellows should know the type and amount of coverage provided by their educational program, and whether it continues after they leave the program. They should know how a claim during residency or fellowship might affect their ability to obtain future liability insurance. Finally, they should be aware of the potential liability exposure associated with moonlighting or engaging in other professional activities that are excluded from the program's liability insurance policy.⁶⁰

Attending anesthesiologists are liable for care they directly provide to the patient, and the care provided by those under their supervision. Two areas of evolving interest include: 1) What constitutes adequate supervision and responsibilities of the "on-call" attending physician 2) how duty hours regulations affect liability and responsibilities of attending physicians and institutions when patient care errors are identified.

Legal aspects of medicine affect all individuals and institutions at all levels of training programs. As the practice of medicine changes, so does the interpretation of pertinent laws.

ASA Closed Claims Project

The ASA Closed Claims Project was started in 1985 by the ASA Committee on Professional Liability in the midst of a medicolegal liability crisis. The goal of this project is to identify recurring patterns of anesthetic injuries and their associated contributory factors from closed anesthesia malpractice claims. The intent is to then modify or eliminate these associated factors, and reduce the incidence of these injuries, thereby reducing medicolegal liability.

The ASA Closed Claims Project works with professional liability insurance companies from across the country that allow trained on-site ASA members access to their closed claims files.⁶¹ Claims are reviewed using a detailed data collection form to collect information on the year of event, demographics, procedure, monitoring utilized, type of anesthetic, alleged damaging event, complications, severity of injury, assessment of standard of care and preventability, and medicolegal outcomes including cost of defense, settlements, and judgments. These forms are then sent to a centralized location at the University of Washington Department of Anesthesiology and Pain Medicine where they are reviewed by two members of the ASA Closed Claims Committee. Any unresolved questions are sent to a third reviewer. This information is then entered into the ASA Closed Claims database. Topics of inquiry are examined for associated factors that may provide clues as to etiology, management, or preventability.

The ASA Closed Claims Project has been credited in part, in an article in the *Wall Street Journal* (June 21, 2005), with changing the practice of anesthesia from one of the highest risk medicolegal professions to one with low to moderate risk. This transformation occurred as a direct result of identifying recurring patterns of injuries and associated factors, and making changes to improve patient safety. The proportion of anesthesia claims for death and brain damage in the ASA Closed Claims Database has decreased from 56 percent in 1975 to 27 percent in 2000 (Figs. 1a and 1b).⁶² Consequently, malpractice premiums for anesthesiologists have dramatically decreased, while other specialties have seen their premiums escalate.⁶³

Data collection from 22 malpractice insurance companies continues today and comprises approximately 36 percent of practicing anesthesiologists in the United States. Brief and limited data analyses on specific topics are available to ASA members by accessing the ASA Closed Claims website (www.asaclosedclaims.org) and completing a data request form.

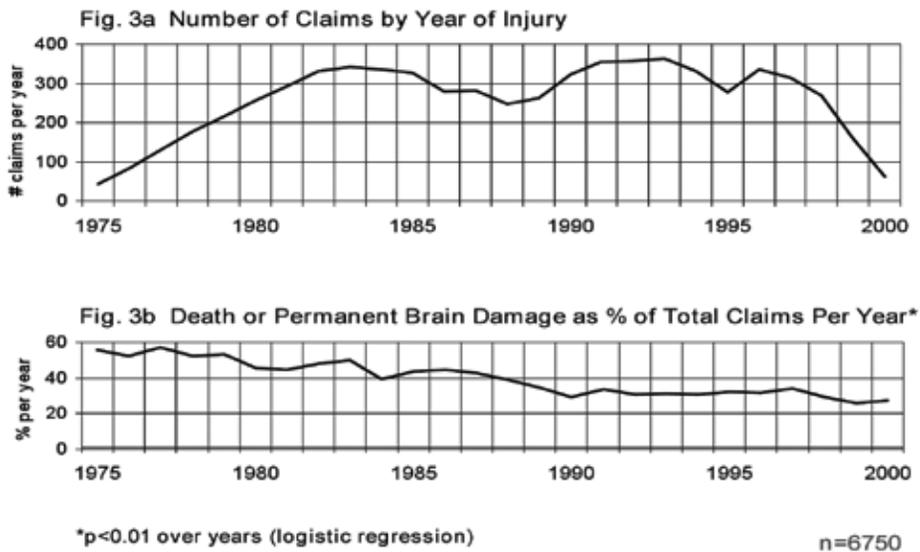


Fig 3a and Fig 3b from Cheney et al. *Anesthesiology*. 2006; 105:1081-1086.

SUMMARY

Litigation is a highly stressful event for physicians and their families. Understanding the litigation process as well as active participation in the defense process should establish some control in this difficult situation and maintain psychological well-being. Steps required to minimize the risk of liability include adequate communication with patients and their family members during preoperative evaluation and obtaining appropriate informed consent as well as adhering to the standard of care and maintaining adequate record keeping. In addition, appropriate response to a medical error or negative outcome should further reduce the chances of lawsuit.

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