Central Line

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(SOUNDBITE OF MUSIC)

VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome to another episode of Central Line. I'm Dr. Adam Striker, your editor, and today I'm talking with Dr. Franklin Chiao, an anesthesiologist specializing in pediatric and acute pain management. He's also a member of the Professional Liability Committee who lectures and publishes on the topic. Dr. Chiao practices in New York as part of a multi-specialty group. Dr. Chiao, thanks for joining us today.

DR. FRANKLIN CHIAO:

Thank you for having me.

DR. STRIKER:

Absolutely, I wanted to just maybe start out with the basics real quick to get it out of the way. What is medical professional liability insurance and as an anesthesiologist, why do you need it?

DR. CHIAO:

Insurance overall is, is a way to mitigate risk for bad outcomes and in particular, for medical insurance, the bad outcome would possibly result in a lawsuit. And in that case, most doctors and health care practitioners would like to be insured against a bad event or bad outcome.

DR. STRIKER:

How did you get involved in, in this area of anesthesiology practice?

DR. CHIAO:

So, I grew up in a family of doctors, and unfortunately or fortunately, I, I saw firsthand from the doctor's perspective how much psychological toll it can take on a person who spends their whole life dedicated to patient care. And I also worked on the other side. I worked in high school at an insurance company for a few weeks, and I saw how comprehensive and sophisticated the information they have and different models for predicting risk of bad outcomes and deciding on premiums. And then in addition to my medical studies, I worked in finance and I have a finance degree. So, a lot of the probability and insurance, insurance modeling is based on a lot of mathematics, so the whole field of liability became interesting to me.

DR. STRIKER:

Fantastic. Have you always been involved in it since you've been in practice or is this something you picked up some years down the road after you finished training?

DR. CHIAO:

So, and, and typically in medical school, we have a well-roundedness course where physicians will talk with the students about practice issues which include malpractice, but there's not a whole lot dedicated to that. But I definitely became interested because I saw firsthand what can happen and also just, you know, to become a good clinician, I wanted to learn the best practices.

And then through the ASA, which I was always involved with, I applied for the Professional Liability Committee and I was one of the junior members but got really involved and we wrote the Professional Liability Manual, which we revised, and I think it was published in 2017. And it's a great resource for anyone practicing in the field. And then I got more involved with digital media and social media. And then this opportunity came up.

DR. STRIKER:

Great. One common thread that we always seem to delve into on this podcast is the involvement with ASA committees and the Society at large and just professional citizenship. How do you decide to apply for this Committee in the first place? Did you have a mentor or did you have someone that said, hey, this might be a good idea?

DR. CHIAO:

I really learned a lot about the ASA as a resident and met so many great people and presented research. Then I saw in the ASA Monitor ads for committee applications and encouraging all people, senior and junior, to apply. In particular, this Committee I was interested in because it was a mix of senior and junior faculty. And also, I wanted to improve my own skills. And then eventually, as I got more involved, reach out to the community more to help advocate and improve risk management for any physician who's interested.

DR. STRIKER:

Well, let's get into some more specifics now as far as professional liability insurance. What are the professional requirements? In other words, are there minimum requirements for everyone? Is obtaining professional liability insurance part of the licensure process? And do these vary state by state?

DR. CHIAO:

So, it's largely a state regulated industry, insurance, that is. And in terms of do you need insurance? Well, it's a good question. Essentially, without insurance, you're taking a lot more risk. You're obviously saving the premium, which you're not paying, but most facilities and medical and hospitals that I know require their doctors and health care practitioners to have liability insurance for several reasons.

First, if you don't have any insurance, it's hard to go back into getting insurance because when you didn't have insurance for a certain amount of time, then when you get insurance again, it's difficult to really assess how high risk you are or low risk. And then if you do get a claim in the past that can really affect your ability to practice. So for that reason, most importantly, most practitioners usually are required to get insurance.

DR. STRIKER:

Can you explain the difference between the different kinds of insurance you can obtain?

DR. CHIAO:

So the two main types are occurrence and claims made. Occurrence is the more expensive and also more comprehensive malpractice insurance because it covers every time period where the anesthesiologist was performing cases. But on the other

hand, claims made only covers cases during the period that they had the insurance. So as an example, if you were working at a hospital from 2018 to 2020 and you had claims made insurance, but then the patient filed a lawsuit in 2021, you wouldn't be covered unless you had an additional tail coverage. So tail coverage will cover any malpractice lawsuits that are filed after the person left the institution or hospital.

Occurrence, on the other hand, you don't need a tail coverage because you would already be covered for that time period where you're working, no matter when the lawsuit was filed.

DR. STRIKER:

Well, let's tackle a, a topic that I know is of interest to many, many of our listeners, social media, cell phone use. The accessibility we have now is so great, and the way we communicate has changed so much in the last several years. What impact has this shift in communication had when it comes to liability?

DR. CHIAO:

Mm hmm. That's a great question. Social media, they're designed to really capture the user's attention, as well as anyone who's looking at online social media accounts. And the one real risk that's commonly encountered is the reflexive posting and usage of it during clinical care and all of the social media that's posted on someone's account. And it's always, it's actually becomes part of the public. And people often think that deleting social media posts will exclude them from any liability, but they're all discoverable once it's posted online.

Also, it's not uncommon to see HIPAA violations and slight modifications of a case that are described, but actually other people who may have been involved in the case in some manner may be able to recognize private information that was posted and figure out which case the person is posting about.

There were a few cases not even really related to malpractice, but lack of professionalism that was encountered with social media. I think it was the New York Med TV show. There was a nurse that posted a photo of how messy the trauma room was after a case, and there was nothing about HIPAA or any violation, but it showed poor judgment and made the hospital look bad. So, I think that person was terminated.

In terms of more specific areas, if you're posting about medical devices and you have a conflict of interest, the Federal Trade Commission requires that you disclose

it on your social media account or post. So there's some little quirky rules and, but those are the main issues, the privacy, the timing, everything is public and also being careless about being professional, and some people put a disclaimer on their social media that this is my own personal opinion and I don't represent the hospital or my department or group as a way to lessen any misunderstandings that can come from posts that they make.

DR. STRIKER:

Well, let's get into a couple of grayish areas when it comes to cell phone use in the OR and or social media. Let's say I'm, I'm in a case and I think, you know, I'm not going to post anything, so I don't have to worry about there being a record of me interacting with the internet in any way while I'm in my case. But I'm going to browse the internet while I'm engaged in an anesthetic on my phone, or I'm going to use the phone. And my second question goes along with that. I'm going to just maybe text my partner or communicate with them. Nobody's going to really know the difference. Or, you know, maybe I'm using it for professional reasons. I guess those couple areas, I'd want to get your opinion on. How does that look when it comes to professional liability? Or what kind of effects might that have on the practitioner?

DR. CHIAO:

So, for an actual case and claim to occur, they need to show a breach of duty and something that the practitioner did that caused the adverse outcome. Without those, there aren't really that many issues with using the internet or your phone in the operating room. But in terms of professionalism and patient care, they always love to talk about this at a lot of the ASA meetings, it's called the distracted anesthesiologist, where you're not focusing on the patient as much as you should be. You'll be texting about personal things. And then if for some reason there was an adverse outcome and a claim or lawsuit that was put forth, they are able to look at your text messages and data, who you were calling, which numbers, and those could end up putting you at a much worse, more liable position.

In addition, there's a lot of issues related to hacking of personal data. One of the main risks is that you can be texting about a patient to a colleague. But what if someone ended up breaking into your phone, posting this? Then that's also a HIPPA violation that itself could lead to a malpractice case.

They did create special doctor to doctor communication portals now for any health care practitioner, not just doctors, and one example is it's called TigerText. It's encrypted communications. The software is installed by a special IT person onto

your mobile device. The other person has the same software installed. There's usually two sets of passwords. And the way this improves safety is that hackers are, have a much harder time breaking into the phone. So in general, using personal devices and communication about non-work related matters is always not a good practice.

DR. STRIKER:

And I think we would all agree that certainly not being a distracted anesthesiologist is paramount and not doing anything that's not related to the care you're giving is, is critical so that the anesthesiologist can devote their full attention to the patient. But there are times where you have to communicate with your partners or a board runner or another surgeon or someone else related to patient care, and to those individuals that might be scared to even send a text that has nothing to do with specific patient information, but more about logistics. To those people that don't want to even open the door to any issues, do they have something to worry about in that regard?

DR. CHIAO:

So, I think if you're texting about work related issue to your clinical floor leader or some, some patient related issue that, of course, would be seen in a much better light. But there are also other ways to communicate, through like the secure physician portal, you can use the hospital phone line that's in the operating room. Those are other, more secure phone portals. Cellular data is much easier to break into.

But of course, there are emergencies that come up, and some people have the intubation phone or the trauma phone, and they have to answer the phone calls. And in those circumstances, there will be other witnesses in the room to vouch for you. And in any event, they would be a witness and say he was taking care of the patient, but then he also had the trauma phone and had to communicate about a very sick patient.

DR. STRIKER:

Another controversial topic I want to get your thoughts on is pregnancy tests. What do our listeners need to know?

DR. CHIAO:

Mm hmm. So pregnancy tests, obviously, any woman of childbearing age could be at risk when they're getting anesthesia. I believe it is nitrous and some other intravenous agents that are the most risky. And I believe also it was first trimester, the fetus is at most risk for developing anesthesia related issues. So, of course, it's always great to get a pregnancy test. Most people around the extremes of age, they don't think, take it as seriously. So like a 12 year old, do you really think she needs a pregnancy test, or someone over 50? So, for that reason, there are some guidelines that vary at different institutions. Some require everyone to get a pregnancy test. Some require urine or others require serum blood tests. It is a guideline, and other institutions will take the patient's word as truth. So, it varies overall from institution to institution. The ASA has a nice guideline put out about pregnancy testing,

DR. STRIKER:

So, it's fair to say you should familiarize yourself with not only your institution's rules, but also state laws that might apply differently based on where you're practicing?

DR. CHIAO:

Yeah, definitely. The standard of care has a big influence on malpractice and, and outcomes.

DR. STRIKER:

Great. Well, let's talk a little bit about responsibilities and who they adhere to. For example, who handles the management and documentation needed when a complication arises?

DR. CHIAO:

Ultimately, the anesthesia attending or physician on the case has responsibility for the documentation and any patient care. However, there is a lot of supervision involved, and the anesthesia attending himself does not need to be always involved with writing every single note and taking every consent. But he should at least have definitely looked at all the documentation made sure the consent was signed. So, people like to say the buck stops here, but that doesn't exclude any other person who is being supervised from being in a malpractice suit.

DR. STRIKER:

So, whether you're working with residents, nurses, et cetera, even though you're the one responsible, everybody potentially could have to answer questions or be subjected to that lawsuit?

DR. CHIAO:

Yes. Definitely. And in, in fact, often when a lawsuit is filed for malpractice, they actually name every person that was involved in the case, anyone's name that was in the chart. So obviously, as the case progresses and the discovery process goes on, certain people will be excluded because they weren't really at fault or weren't involved heavily. But usually, they'll name almost everyone involved in the case, even if there was no research done besides looking at who was in the case.

DR. STRIKER:

Do people often get dropped then in those instances?

DR. CHIAO:

Yes, people often get dropped. And in fact, only 2% of cases have claims paid annually and three quarters of any malpractice suit, there's no payment involved at all, and only one out of ten cases go to trial.

DR. STRIKER:

When their situations where multiple doctors are involved, who is typically covered or is there no typical situation?

DR. CHIAO:

So, you could have the same surgery and different people involved, different patient, and the circumstances would be similar, but each malpractice case is different. So, for example, if there was a neurosurgeon involved, if there was an anesthesiologist, each doctor would have their own insurance. Sometimes it's through the hospital and in terms of placing the onus on, on different people that would be sorted out through the discovery process, review of medical records, discussion with expert witnesses.

So, it's not always clear cut, but in some cases, if, for example, there was an aspiration during a colonoscopy case, that would also be a, a more controversial one because the endoscopist is doing the procedure and then the anesthesiologist is

anesthetizing the patient and managing the airway. So in that case, it would be more difficult. But if it was a neurosurgery case and the patient aspirated, that would probably be more, the onus would be placed more on the anesthesiologist because the neurosurgeon is not doing anything involving the stomach or the colorectal system that might cause aspiration.

DR. STRIKER:

This brings up a, another question I wanted to ask, which is, let's say you disagree with care provided by another physician, and they actually mention that in the chart, or they call out specifically your actions as the anesthesiologist. We've all been taught the medical record is not a forum to have any kind of disputes or arguments, but what advice would you give to an anesthesiologist who sees that, something like that occur and wants to respond appropriately to, just to defend themselves?

DR. CHIAO:

Mm-hmm. This is a very difficult situation and not all that uncommon. It sounds like a very difficult case and anything that involves something like this where one doctor says one thing, you have another opinion, and they have the gall to write it in the chart, I would probably suggest not writing back or responding and creating a chart war. I would probably ask my supervisor or someone that would be able to have some sort of mediating effect. Obviously, any party that's involved in an adverse outcome, they'll be a little emotionally overwhelmed and they're not in the best position to, to sort out any chart or documentation or so. Probably getting the advice from other colleagues who have had similar situations, and they may be on more friendly terms with the surgeon or the surgeon's Chairman. That would probably be the best way to sort it out because anything in the chart that's documented that makes one doctor look bad or makes another person look bad, it can all be used as ammunition in a liability case.

DR. STRIKER:

Ok, well, let's say, you know, I'm looking at the chart and I know I did the right thing and I see another service, you know, basically call out the anesthesia practice or, or behavior, behavior in terms of what I was administering medically, and imply that that might have been a problem. And I want to defend myself and I'm like, If I just let it go, someone that looks at the chart is going to look at it and say, well, obviously the anesthesiologist was at fault. And do I have to worry from a professional standpoint when it comes to malpractice or medical legal risk? If I don't have a response, even if I try to address it professionally with the department head or with

my, my superiors. I'm worried that, that's, that record is there. Do I have anything to worry about medical legally in that regard?

DR. CHIAO:

Mm hmm. Well, for documentation, it's always best practice to have very legible and clear notes, and this includes writing the time, signature, describing any major elements of the case, like positioning, surgeon requests. So, in terms of documentation, it definitely helps to describe events and after an adverse event to describe any conversations that were held, but to have some sort of back and forth with other surgeons, it probably wouldn't result in the best outcome.

DR. STRIKER:

Let's talk about time outs. Who typically initiates them, and if the anesthesiologist is that person, what are the liability implications for him or her?

DR. CHIAO:

Mm hmm. So I've worked in facilities that had no time outs and then I've worked at some that did time out on everyone, and then I also worked on the Time Out Committee. So essentially, a time out is another safety check, and so much of risk management for professional liability is just improving quality and safety. So there's no one in particular that has to run the time out. It's a team oriented process. I've seen nurses do it, surgeons, anesthesiologists. Most often it's usually the nurse because the anesthesiologist is attending to the patient, the surgeon is getting ready for the surgery.

So, in terms of who runs the time out, it can be anyone. But the liability is basically a team approach. So, if the time out wasn't done, everyone involved would be at risk. And the time out in particular is a great thing for patient safety. And it helped to eliminate a lot of wrong sided surgeries and nerve blocks and has improved safety greatly.

DR. STRIKER:

Let's dovetail on what you just said and talk about specific situations. You mentioned wrong sided surgery or nerve blocks. Are those amongst the most common problematic scenarios that anesthesiologists should be aware of? And if so, what are some others?

DR. CHIAO:

So, in terms of the most common liability events, it can vary depending on the specialty. So, for example, in pediatric anesthesia, most claims are from respiratory arrest. That's a common, in terms of bad outcomes that's usually respiratory related in pediatrics and other specialties, for example, in obstetric anesthesia there, high spinal and nerve injuries are often more than more common liability cases. And then overall, if you look at the Closed Claims database, there's aspiration is a common event dental injury not often resulting in lawsuit, but pain into the patient for implant or dental work that needs to be done.

DR. STRIKER:

You mentioned dental. What is the best practice if you have a dental injury? We know it's a, a risk with airway management. What should the anesthesiologist do in that instance?

DR. CHIAO:

So, in the case of a dental injury, a best practice would be, obviously to look for the tooth if it fell out. If, if you can't find the tooth, they often get an x-ray and in some cases, if it was in the airway, they need to get an ENT consult. If the tooth was found or just damaged slightly. In the worst case, they would pay for an implant. But one of the reasons I love pediatrics and taking care of small kids, baby teeth. Baby teeth are going to come out anyway, so there's no major issue with them as long as you can find the tooth.

DR. STRIKER:

Correct me if I'm wrong, I always thought positioning injuries were probably the top anesthesia claim. Is that still the case, or, or is that outdated now?

DR. CHIAO:

The data changes every now and then, but nerve injury is definitely a common occurrence from positioning, also from doing regional anesthesia. There are cases of nerve paralysis from blocks. It's much less common now with the use of ultrasound guided techniques and nerve stimulators, better needles and technology.

DR. STRIKER:

Regional anesthesia has been shown to be extremely safe, especially in pediatrics, where I, I mean, larger studies that have been done just don't show any significant neurologic deficits. Is that the case across the board? Or at least in your experience with regard to claims and potential medical legal issues or lawsuits or issues that patients have had? Because I, I know we've certainly made regional anesthesia extremely safe and in, incredibly effective, and I just want to make sure we touch on whether that is indeed a, you know, an issue or not in terms of medical legal risk.

DR. CHIAO:

Regional anesthesia is definitely extremely safe. But there are ways that it can become safer and practitioners can improve their safety and quality for doing blocks. Some of these include using ultrasound and nerve stimulator ultrasound. As you know, you get a better picture of the anatomy that you'll be anesthetizing. Also for nerve stimulator you, you get a proximity to the nerve, and also one advantage of nerve stimulator is that if you're too close to the nerve and you're on a very low, low frequency stimulation, oftentimes that means you're actually in the nerve sheath itself, and that can be quite high risk for nerve injury.

Another safety mechanism for regional anesthesia is using pressure manometers. There's some research in animals that showed high pressure injections greater than 20 PSI was also high risk for nerve injury. So regional anesthesia itself is not any more risky than any other aspect of anesthesia. But you definitely need to stay up to date. Enhance your ultrasound skills, go to conferences. See what the latest local anesthetics that are being used and in small places, it's also can be more difficult, often because the ultrasound machines aren't available or they're using older ones. So you really have to advocate for yourself. Try to get the best equipment.

DR. STRIKER:

I, I just want to make sure that, that people are aware that, you know, that regionally, anesthesia overall is, is, is very safe and that if you know, if patients are listening, talk to your anesthesiologist if you have any concerns. And, I wanted to talk about another situation, which is, let's say you have an area of expertise. Your partner may not be quite as adept, and they end up doing a case that you would otherwise do for whatever reason, staffing issues. Is that something people need to worry about, or is that not a concern if you're both credentialed properly?

DR. CHIAO:

Mm hmm. So this is a very challenging question. I've had a situation where I was the only person who did a certain regional technique and I was about to leave for the day and then the surgeon wanted me to do it. But then the other anesthesia attending was on call, so I ended up staying to help out. But in the event that I didn't stay and the person was staying and they didn't know or weren't comfortable doing that particular technique, they would have just done a general anesthesia. So, if there's no adverse outcome, sometimes it is the case where patients do get less than optimal anesthetic just due to convenience or staffing issues. But as long as there isn't a bad outcome, the anesthesiologist shouldn't be worried about making themself more at risk for a lawsuit if they're doing a technique that they're more comfortable with, even if the surgeon wanted something else.

DR. STRIKER:

Ok. What responsibilities do patients have and, when it comes to liability?

DR. CHIAO:

So it's actually pretty interesting. It's very rare, if ever, that a patient will get sued. In fact, I haven't really heard of that happening at all much, as doctors and health care practitioners, we're shepherding the patients who know nothing sometimes about medical issues. We're taking care of them and guiding them through a scary process of having surgery and in an unfamiliar place, and they're sick and need help. So, the patient really doesn't have much risk for liability. But of course, as with anything, having a good relationship with your doctor, showing up on time, following all the, all the instructions, those are all things that will improve outcomes. And in fact, patient engagement now is a really hot area of discussion and enhanced recovery after surgery protocols have really made patients more engaged and outcomes have also improved.

DR. STRIKER:

Let's talk best practices. Let me hear what you think are some best practices, maybe things that we haven't touched on yet.

DR. CHIAO:

So, it's common sense, but bedside manner is always a great, great practice. I've worked with a surgeon once who had bad outcomes and wasn't a very good surgeon. One day my colleague had to come in on call at 7:00, start the case at 7:30. I came back the next day at 7:30, he was still doing the same case, so I was

shocked when I, I saw the patient post-op day one and they said, oh, the surgeon was amazing and they're great, so bedside manner can go a really long way. Patient physician relationship is a, really an amazing thing, so that can be a definite best practice.

There's some studies showing that more time spent with the patient can also increase patient safety and reduce risk of liability. Also, you have to know yourself as an anesthesiologist or a practitioner. If you're not good at a certain procedure or technique, or you rather go at a slower pace, maybe working at a quick paced ambulatory surgery center is not the best situation for you. But if you don't, didn't have any cardiac anesthesia training and you're working at a major tertiary hospital with doing cardiac cath lab cases and EP lab all the time, that's also probably not the best situation for you. So you have to find a group where you're comfortable.

And as I mentioned before, documentation is really important. Don't go back to the chart and change notes. You always want to be legible. Right the time down. In terms of the case itself, you want to discuss positioning, surgical requests, correct any, anything with a cross out and an initial if needed. You don't need to cross everything out just with one line.

Also maintaining a professional image online, if you're doing social media. Probably not the best practice to post too many personal things and anything that may reflect poorly on you. In terms of the standard of care, you always want to keep abreast of your ASA guidelines and local practices. Some lawsuits focus more on the local standard, and other ones focus more on the national standards, so you should really keep up with both. As an example, New York has a law that you need continuous EKG anesthesia cases. Also following up on lab tests is good, especially if you ordered them. If there's an abnormal result, you should really note that. Following up with consults and knowing the entire chart is definitely helpful because if there's any medical lawsuit, they'll be looking at the entire chart.

Also, there are some other more economic issues. There's some discussion about don't waive bills after procedure after an adverse outcome, because that may be seen as an admission of guilt, but that's also controversial.

And other issues that are best practices, any notes that you take or conversations about the case could be discovered, so you really want to be careful about any notes you're taking or writing. If there's any bad case you should get hospital risk management involved and also discuss it with your team and your department supervisor.

DR. STRIKER:

Well, there's one question that I think it's important that we ask, because it's something that comes up whenever we talk with our residents or other colleagues when we discuss malpractice or liability. Do you go and say you're sorry? What do you do when you make a mistake? What should the anesthesiologist do in that instance?

DR. CHIAO:

So, this is a great question. There are laws that are called apology laws. A number of states have this where any apology saying sorry cannot be admissible into a court of law. The apology law is helpful in that it allows you to comfort the patient and say sorry and apologize, but that wouldn't be a, an admission of guilt or it wouldn't be allowed into evidence. And one thing to note also is, full disclosure of any bad outcome is always a good practice. It's part of having a good bedside manner. It's always good to do it in a private area and to have witness there if possible, like a, like a nurse or another staff member and to write about your conversation in the chart afterwards.

DR. STRIKER:

Do you still think that's the best practice? Also, if you're in one of those states that doesn't have one of those laws, not only full disclosure, but use the words I'm sorry?

DR. CHIAO:

So that's definitely a really tough and good question. It would probably depend on the situation, the case and what happened.

DR. STRIKER:

What is your advice in general? Should we not overthink it? We go out and talk to families, obviously, when there's a mistake or some adverse event and always want to be as honest and truthful and forthcoming as possible. But I think that some anesthesiologists may get, for lack of a better term, paralyzed, not sure what to say because they don't want to, they don't want to say the wrong thing one way or the other. Do people overthink that?

DR. CHIAO:

I think that's a great question. Any time there's a bad outcome, I would recommend a full disclosure. I would take time to gather thoughts and discuss it with risk management or a supervisor in the same department and really go over ideas about what you would want to say in particular, if you're having difficulty putting something together yourself.

There are workshops about delivering bad news. It's better to deliver the bad news up front rather than at the end of a conversation. So, a lot of malpractice insurance companies also give workshops about best practices, how to deliver bad news, and disclosing a bad outcome is definitely something that should be done regardless of whether your state has an apology law. I wouldn't necessarily say sorry or apologize, though, if there's no apology law, because that can be controversial, and it would depend on the situation.

DR. STRIKER:

Well, and I think obviously there's a, there's a couple of different ways to, to use that term. A lot of us presented with a situation like that just want to express our sympathy and share that grief or that emotional moment. And oftentimes the phrase I'm sorry is a mechanism to achieve that. And so obviously different than saying, I'm sorry I did this or I'm, you know, I'm sorry, I didn't mean for that to happen. Or it just it obviously depends on the context, wouldn't you say?

DR. CHIAO:

Mm hmm. Yeah, it's a, it's a difficult situation.

DR. STRIKER:

Well, before we leave everyone, what are some good resources or avenues, if any listeners have questions about professional liability?

DR. CHIAO:

In terms of getting a first start in the field of anesthesia professional liability the anesthesia ASA Professional Liability Manual is a great step. I believe it's on the ASA Professional Liability Committee page. There are also other online resources, in particular online education courses from your malpractice carrier, and there are also quite a few good resources that medical students can have. The American Medical Student Association has other good resources and handouts. Conferences are always a good, there are always a number of lectures about malpractice.

DR. STRIKER:

All right. Well, thanks. I think that's, that's really helpful. Dr. Chiao, thanks again for joining us today. It's been a great conversation and look forward to seeing you soon.

DR. CHIAO:

Thank you.

DR. STRIKER:

This is Dr. Adam Striker thanking everyone for joining us again on another episode of Central Line. Please join us again next time.

(SOUNDBITE OF MUSIC)

VOICEOVER:

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