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, 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.

In this edition of the manual, we have attempted to discuss variations in the law, as well as highlight new areas involving the practice of anesthesia and any associated liability. Another change from the last edition is that we have incorporated a question-answer format to the topic discussions. 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

How often are physicians sued and who is at highest risk?

Every year, 1 in 14 physicians will face a malpractice claim. Jena et al.2 found that 7.4 percent of all physicians annually faced a malpractice claim and 1.6 percent made an indemnity payment. However, the rate of claims for all specialties has decreased substantially since the early 1990s.3 The reasons for the decreased rate of malpractice claims include improvements in patient safety, establishment of disclosure and apology programs, and tort reform in many states, including damage caps and statutes of limitations.

Malpractice risk varies by medical specialty. Malpractice claims were more frequent in neurosurgery (19.1 percent of neurosurgeons faced a malpractice claim annually).2 Other types of surgeons frequently faced a malpractice claim annually (thoracic-cardiovascular surgery [18.9 percent], general surgery [15.3 percent], and orthopedics [14 percent]).2 In contrast, lower proportions of physicians in family medicine (5.2 percent), pediatrics (3.1 percent), and psychiatry (2.6 percent) had a malpractice claim annually.2 Annual claim rates for anesthesiologists was 7.3 percent, very similar to the average rate for all physicians. By age 65 years, 75 percent of physicians in low-risk specialties and 99 percent in high-risk specialties had faced a malpractice claim.2

In addition to medical specialty, physicians with more paid claims had a high risk of recurrent malpractice claims.1 Physicians with three or more paid claims (4 percent of physicians) had more than three times the risk of another paid malpractice claim compared to physicians with only one paid claim (84 percent of physicians). Male physicians had a 30 percent higher risk of a paid claim than female physicians.4 Although the characteristics of high-liability risk physicians beyond specialty aren’t completely known, communication problems and shorter visits (not quality of care) may play a role.5 Error in diagnosis is the most frequent allegation, ranging from 3.5 percent in anesthesiology to 87 percent in pathology.3

What is the outcome of most malpractice claims?

Most claims do not result in payments to plaintiffs. Jena et al.2 found that 78 percent of claims did not result in a payment to claimants. Likewise, the Physician Insurers Association of America (PIAA) found that 64 percent of claims were dropped, dismissed or withdrawn by the plaintiff because they lacked merit.7,8 Twenty-seven percent of claims were settled, 5 percent were decided by alternative dispute mechanisms and 7 percent were resolved by trial.7,8 A defense verdict was obtained in 90 percent of jury trials.9 Over 75 percent of all malpractice claims did not involve any payment to the plaintiff.6,7

Specialties that more often faced a high claims frequency often are not the specialties with the highest average payments.2 For example, the average payment for neurosurgeons ($344,811) was less than the average payment for pathologists ($383,509) and pediatricians ($520,924), even though they had more claims per year. The specialties with the most payments exceeding $1 million are obstetrics and gynecology, pathology, anesthesiology and pediatrics.1 The percentage of claims with $1 million or more (inflation adjusted to 2012 dollars) in payments to plaintiffs was 9 percent in 2012, with 24 percent of claims resulting in payment of $500,000 to $999,999.8 Payments are associated with severity of injury, especially with need for long-term care with permanent disabling injuries that require long-term care, such as injury to the brain or spinal cord.

What are the defense costs associated with malpractice claims?

Average defense costs per claim were $40,649, ranging from a low of $22,163 among claims that were dropped, dismissed or withdrawn, to a high of over $100,000 for tried cases.9 Defense costs continue to increase over time.8

If a payment is made on my behalf, will I be reported to the National Practitioner Data Bank?

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 his or her behalf. However, many claims are settled on behalf of institutions alone, instead of individual physicians, and therefore institutions are not required to report claims. The NPDB only provides a sampling of national statistics on medicolegal payments, although 46 percent of hospitals had
What are the malpractice risks for anesthesiologists?

Anesthesiologists have an average number of malpractice claims. However, anesthesiologists have higher indemnity payments due to the high severity of many anesthetic injuries (e.g., hypoxic brain damage, spinal cord or disabling nerve injury). Anesthesia-related cases accounted for only 3.3 percent of 2012 NPDB reports, but the median payment was relatively large ($239,980) and was significantly increased compared to the cumulative inflation-adjusted median since 2003 ($200,000). Anesthesiologists also are in the top four of specialties with payments exceeding $1 million. Anesthesia 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 $17,215 in 2016. Premiums for pain medicine anesthesiologists average 20 percent higher than for anesthesiologists who do not practice pain medicine, due to the higher risk of many pain medicine procedures, including cervical epidurals, opioid medication management, and device implantation or management.

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

Definition of Malpractice

What elements must be proven to establish liability under a claim of negligence?

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.

What is the duty owed to a patient and how is it determined by the court?

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. Some have suggested that the locality rule is no longer relevant given the ease in exchange of medical information in a growing electronic environment along with emphasis on lifelong education and national medical education. Furthermore, the locality rule may foster substandard care by physicians who are fearful that adopting up to date and evidence based practices may breach a local standard, yet inferior, standard of care. To this day however, jurisdictions remain split as to whether they use a national or some version of a locality standard of care. 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. The AMA has published guidelines to help ensure objective and unbiased testimony. Members providing expert witness testimony may suffer censure, suspension or even expulsion from the AMA when deviating from these guidelines. 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 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.

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.

What measures must be proven to establish causation for an injury suffered by the patient under a claim of negligence?

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.

What is required to establish a successful claim under res ipsa loquitur?

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.

If the patient would have succumbed to their condition anyway, are physicians still liable for any negligent care provided to that patient?

Some jurisdictions allow for claims for loss of chance liability. Under a traditional negligence analysis, if a patient has less than an even chance of survival from their condition, a physician who breaches the standard of care in treatment of that patient would escape liability as it is would be more likely than not that the patient would have died anyway. However, some jurisdictions adopted the loss of chance doctrine to allow plaintiffs to recover damages due to the proportion of injury that the physician caused the patient. Award damages are based on the proportion that the physician’s negligence had on lessening the likelihood that the patient would have a favorable outcome.
Types of Damages

What is the difference between general damages and special 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.

Can damages be awarded for reckless behavior on the part of a physician that was unintentional?

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

What are the determinants of a malpractice settlement?

The decision to settle a malpractice claim involves the balancing of several considerations and does not necessarily imply that the physician committed malpractice. In instances where a physician clearly fell below the standard of care, that is an action or omission by the physician clearly injured the patient, it may be to the physician’s and insurer’s advantage to settle those claims quickly. This could avoid a trial and the potential of a jury award that exceeds the limits of the physician’s insurance policy.

In most cases, there is no clear liability on the part of the physician. Therefore, the physician and insurer must decide whether the chance of a defense verdict in a trial is worth the risks of a bad outcome and potential of a large jury award. That calculation depends on some factors that can be quantified, such as the extent of the patient’s injuries, medical costs to care for the patient because of that injury, loss of income, ability to return to work, etc. Other factors are not as easily defined in terms of dollars, such as pain and suffering, effects on the patient’s spouse and children, and other such factors. Most insurance companies have experts on their staff that can help evaluate each case to determine, on balance, whether it is better to push for a settlement or to go to trial to show that the physician should not be held liable for the patient’s injury.

In those cases where the physician wants to settle the case and the insurance company does not do as much as possible to do so, such as offering reasonable payments to settle the case, the insurer opens itself to a claim of insurance bad faith if a trial results in a verdict that exceeds the limits of the physician’s policy. That is a large incentive for insurers to settle cases whenever possible.

The size and frequency of payments in malpractice cases vary cyclically, with varying numbers of cases filed and payments made on an annual basis. Insurers must evaluate the national and local markets to make predictions concerning the range of costs it is likely to incur to fairly price their policies.

The bottom line is that deciding which cases to settle and which to take to trial is both an art and a science. Each case, each individual injured patient, and each physician accused of causing the injury are different. There is no magic formula that applies in all cases. The outcome in one case does not guarantee a similar outcome in another case, even if the facts are similar. Physicians involved in malpractice suits should consult their insurance carrier and jointly determine whether it makes sense to settle the case or to fight the allegations.

What is the relationship between settlements and quality of medical care?

The purpose of a malpractice settlement is to deter negligent behavior by health care providers and to compensate claimants for injuries due to negligence. 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. Juries consider economic (i.e., medical expenses, loss income) as well as non-economic damages. Generally, non-economic damages include bodily harm (i.e., disfigurement, emotional distress and loss of enjoyment of life). 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.

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How to Minimize the Risk of Liability

Physician–Patient Relationship

Why is the physician–patient relationship important for professional liability risk reduction?

A number of studies have evaluated the characteristics of patients that bring medical malpractice suits against their physicians. Assuming 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.26,27

How are bedside manner and professional image relevant to this relationship?

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. The ability to establish good rapport in a short amount of time, and to convey a demeanor of caring competence, is critical. If the patient or their family gets an initial impression that the anesthesiologist is sloppy, flippant, careless and/or poorly informed, there is a higher likelihood of litigation after an adverse outcome. In the modern age, patients and family members are also likely to seek information about their physicians via internet resources. For this reason, it is imperative that physicians be aware of their digital footprint (i.e., Google search results) and take care whenever possible to ensure it is accurate and reflects favorably upon them (see section on social media).

What non-physician factors may be perceived to play a role in the physician–patient relationship?

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.28,29 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.30

Informed Consent

What are the standards that dictate the type of information disclosed to patients through the informed consent process?

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. Justice Cardozo in the 1914 case of Schloendorff v. The Society of the New York Hospital (211 N.Y. 125; 105 N.E. 92; 1914 N.Y.) held that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.” 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.31 More recently, and largely due to variations in what the amount of detail patients may wish to be made aware of, the “particular patient standard” has been applied in some states. Being an subjective standard, it requires physicians to provide information that that particular patient would desire.31 Still today, states vary between which of the three standards they apply with some blending of aspects of all standards described.32

What is the difference between patient competence and capacity to consent to care?

There are several elements intrinsic to the informed consent process.33 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. 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 backup 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 or her right of self-determination and is the basis for informed consent.

To what degree does documentation of consent protect one from liability surrounding consent claims?

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 presupposes 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 website-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. As documentation only memorializes that a consent process occurred and not necessarily that it was adequate, use of technologically based modalities should be considered adjuncts and not replacements for the personal exchange of information between the patient and their anesthesiologist.

What are the major types of liability that may follow from consent failures?

Two forms of liability can result from failures relating to informed consent. An intentional tort claim of battery follows in situations when no consent, actual or implied, has occurred. More commonly, a claim of lack of informed consent may be the result. The elements that must be established for a plaintiff to succeed on such a claim include (1) the anesthesiologist did not provide information on the risks, benefits and alternatives to the treatment or procedure; (2) with that information, the patient would have chosen against undergoing the treatment or procedure; and (3) the treatment or procedure was a substantial factor in causing injury to the patient. In general, claims against anesthesiologist strictly for failures of the informed consent process are rare. However, when inadequate informed consent has occurred in cases in which injury has also been suffered through negligent care by the physician, plaintiff’s attorneys may bring forth the argument that the physician failed to properly inform and obtain consent the patient as a means of bolstering their negligent injury claim.
Adhere to a Standard of Care

As medical knowledge and capabilities are continually evolving, how can an anesthesiologist be confident he or she is practicing according to the 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 medical malpractice plaintiff must establish the appropriate standard of care and demonstrate that the standard of care has been breached. One element that may be included in establishing the standard of care is the manner in which the average, prudent provider in a given community would practice, reflecting how similarly qualified practitioners would have managed the patient’s care under the same or similar circumstances. Other elements include published standards and guidelines.

What is the difference between a standard and a guideline?

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.

Do certain medications or techniques confer additional risk?

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.

What constitutes evidence that an anesthetic was conducted 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

There is no medical literature to provide a standard definition for preanesthesia evaluation. This process precedes the delivery of anesthesia, and is meant to identify and manage medical conditions and inherent surgical risk factors to minimize perioperative complications. The assessment may include a review of the patient’s medical record, an interview with the patient, the physical examination, and findings from previous medical testing and consultant evaluations.

What should be some guiding principles for ordering tests or consultations?

Preoperative tests are done with a reasonable expectation that the anticipated benefit exceeds any potential adverse effects and the results may alter anesthetic, surgical or perioperative management. Tests may be indicated for a variety of reasons, including but not limited to:

1. Discovering or identifying a disease or disorder that may affect perioperative care
2. Verifying or assessing an already known disease, disorder, medical or alternative therapy that may affect perioperative care
3. Formulating specific plans and alternatives for perioperative care

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.

What role, if any, should preanesthesia clinics play?

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 or 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. In addition, with the widespread adoption of Early Recovery After Surgery (ERAS) protocols, preanesthesia clinics will play an increasingly more important role in achieving our goals of improved patient safety and outcome.

**Preamesthesia Evaluation**

The methods used for conducting preanesthesia 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.38 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.

**What should the anesthesiologist know about the legal responsibilities of preoperative testing and consultations?**

**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.39 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.

**Preamesthesia 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. Specifically, what is the question you want the consultant to answer? We need to avoid cleared for surgery as an answer from a consultant. A more appropriate result may be “the patient is at low risk for this procedure,” or “based on this patient’s medical history, no further diagnostic testing is indicated.” 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)**

**Why is documentation important?**

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. A purposeful addendum that is written clearly after the fact and indicated as such can be appropriate.

**What are good documentation practices?**

1. Write legibly if a paper record.
2. Document preoperative discussion of anesthetic risks, benefits and alternative with patients, including specific material risks relevant for the particular patient. Also document patient refusal of any care plans, such as refusal of regional anesthetic or blood product administration.
3. Sign, time and date entries in the paper medical record. For electronic medical records, the system generally does this for you.
4. 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). Remove artefactual data (e.g., arterial transducer is on floor, noninvasive blood pressure cuff readings while patient is being positioned) from the electronic record and document if occurring frequently (e.g., $\text{SpO}_2$ decreasing every time the blood pressure cuff inflates).
5. 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.
6. Document all medications administered.
7. Document any surgical requests. Some people recommend documenting the 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.
8. 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. Check O.R. code records to be sure times are consistent with the anesthetic record.
9. Document all patient visits and conversations with family after an adverse event in the medical record and who was present at each conversation.

**What are harmful documentation practices?**

1. Don’t cross out incorrect entries in a paper 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 a paper 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 multi-vessel 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**

**What is vicarious liability?**

Vicarious liability refers to liability incurred by supervision of other care providers under the supervision of a physician. For anesthesiologists, these providers would include residents, nurse anesthetists, anesthesia assistants and other physician assistants, and nurses from the operating room, the recovery room, and the hospital floor and intensive care unit. 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 as training of medical students, respiratory therapists and medics. Such encounters may occur in the operating room during
intubation, 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.

Who are the usual sources of vicarious liability for anesthesiologists?

The primary source of vicarious liability for anesthesiologists is from supervision of nurse anesthetists, anesthesia assistants, residents and occasionally during intubation training for medics and respiratory therapists. For pain medicine anesthesiologists, sources include office nurses, advanced practice pain nurses, and physician assistants. In order to protect oneself, the intensity of supervision should be guided by the degree of competence exhibited by the resident, nurse anesthetist, anesthesia assistant, physician assistant, nurse or advanced practice nurse, as well as their level of training and experience.

How can an anesthesiologist protect himself or herself from vicarious liability?

There is a wide range of ability among individual providers, 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 poorly performing mid-level care providers may be difficult to dismiss because of institutional policies. Careful documentation of their quality of care and/or refusal to follow instructions should be made and sent to the departmental and hospital administrative heads in an attempt to rectify any unsafe situations.

Although the resident or nurse anesthetist and the 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 and is medically responsible for the care provided.

As health care dollars shrink, the anesthesiologist may find himself or herself staffing a larger number of anesthetizing locations. Data on the safety of various staffing ratios have found himself or herself staffing a larger number of anesthetizing locations. Data on the safety of various staffing ratios have found minimums can be minimized by 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. Hospital employees and residents often have different malpractice coverage than attending anesthesiologists. The responsibility for an adverse event will be partitioned considering the particular circumstances of the adverse event. For instance, administration of a wrong drug by a nurse anesthetist (e.g., rocuronium instead of midazolam) would be attributed to the nurse anesthetist. More complex clinical issues, such as management of a difficult intubation, awareness with administration of low doses of anesthetic agents, failure to treat hypotension, premature extubation, are more often attributed to the supervising anesthesiologist. For groups who employ mid-level providers, a group corporate malpractice policy can help mitigate costs and attributions of vicarious liability to individual anesthesiologists.

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. 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.

Disclosure of Medical Errors and Apology

What are the arguments for and against full disclosure of bad outcomes?

Medical error disclosure, including the decision to incorporate an apology, is a complex, controversial and challenging issue. 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. 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. 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. Thus, patients may be less inclined to initiate litigation due to a medical error, particularly if a positive physician–patient relationship exists. Utilizing a full disclosure of medical errors is one component of maintaining this physician–patient 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 health care providers to apologize after a medical error; these laws are designed with the intent to not allow the apology to be admissible as evidence. It is important to become familiar with individual state’s legislation and limitations regarding “apology laws.”

In 2014, there were 27 states plus the District of Columbia requiring the mandatory reporting of medical errors to administrative organizations. 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.

**What process should be taken in disclosing bad outcomes to patients and their families?**

Providing a full disclosure after a medical error is a comprehensive process that requires appropriate preparation, coordination and acquisition of several resources. 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. Make every effort to have all involved parties present 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. The patient and family should be made aware of support services such as social workers, clergy and language interpreters that could be present for 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.
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 reidentify 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.

Table 1. Summary of the key components for an effective disclosure of a medical error

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<th>Preparation</th>
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<tr>
<td>Review the event with the involved parties.</td>
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<td>Plan your discussion with patient or family in advance.</td>
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<td>Select a quiet and private location for the discussion.</td>
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<td>Offer language interpreters, social workers and clergy to be present.</td>
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<td>Have all involved parties at the initial disclosure.</td>
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<th>Delivery</th>
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<tr>
<td>Deliver a compassionate and unhurried explanation.</td>
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<td>Explain the conditions under which the medical error occurred.</td>
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<td>Discuss objectively what you know and don’t know.</td>
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<tr>
<td>Verify that the patient and family understand your explanation.</td>
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<tr>
<td>Describe the previous, current and future therapies.</td>
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<tr>
<td>Describe the process for investigation and performance improvement.</td>
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<td>Consider incorporating an apology for confirmed medical errors.</td>
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<th>Follow-up</th>
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<td>Provide frequent updates to the patient and family.</td>
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<td>Make yourself easily accessible to the patient and family.</td>
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<tr>
<td>Facilitate discussions between risk management, the hospital, and the patient or family.</td>
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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.

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**What to Do When Sued**

### Stages of a Lawsuit

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<th>Stages of a Lawsuit</th>
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<td>Notice of intent to sue or that a lawsuit has been filed served on the defendant</td>
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<td>Notification of malpractice insurance carrier</td>
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<td>Insurer will assign legal counsel</td>
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<td>Defense attorney files answer to the petition</td>
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**When will you know that a lawsuit against you has begun?**

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.

A lawsuit only 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 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 response 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 or she may be a good or 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.

Interactions With Insurance Carriers and Defense Attorneys

When should you alert your insurance carrier to a possible lawsuit against you?

Insurance carriers must be notified immediately after receiving the complaint. The insurance company will hire an attorney to represent you. The attorney owes duties to both you and the insurance company. The duties owed to the insurance company are typically defined by the terms and conditions of the professional liability insurance contract (policy). The attorney owes you a fiduciary duty as the client. This means the attorney must act in your best interests at all times and will protect your interests in the event there is a conflict between you and the insurance company. Attorneys must provide competent representation (ABA Model Rule 1.1), confidentiality and loyalty. The fiduciary duty of loyalty continues after the termi-nation of the relationship. You also have the right to terminate attorney 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 attorney may not withdraw representation without permission from the court. Examples of permitted reasons include: you insisting on a non-meritorious defense, seeking to pursue an illegal course of conduct, insisting the attorney acts unethically, or you are unreasonably difficult to work with.

What are the steps to take when you receive notice of a lawsuit?

- Notify your insurance company immediately.
- Do not discuss the case with anyone, including colleagues or other providers who may have been involved, operating room personnel or friends.
- Do not access the medical record on your own. Records are maintained by the hospital or facility where the anesthetic was performed. Plaintiff attorney may request an audit trail of the medical record which may create suspicion if the physician has been in the medical record after being served a summons. Your insurance company or attorney will supply a copy of the record for you to review.
- Take care when making notes about the case. The plaintiff attorney may subpoena your notes.
- Do not alter any records or make new entries in the plaintiff’s chart.
- Cooperate fully with the attorney provided by the insurer throughout the litigation.
- Be actively involved in your defense.

When should you communicate with your insurance carrier and lawyer?

Throughout the litigation 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 and your insurance company. He or she must keep you and your insurance company reasonably well-informed and respond promptly to reasonable status inquiries. There is a duty for the attorney to communicate settlement offers to you and your insurance company. The attorney has implied authority as to procedural matters, but you and your insurance company typically have the right to make ultimate decisions affecting the outcome of the case. Your insurance company typically has authority to settle if there is sufficient coverage and there is no reservation of rights. However, many insurance policies contain a consent to settle clause that allows the defendant physician to assert some control over the outcome of their case. This might be a reason to obtain alternate representation. A separate attorney may be helpful if the estimated damages are greater than the limits of the insurance coverage, as the physician may be personally liable for the difference. Similarly, if the lawsuit may result in limited or revoked practice privileges, private counsel may be retained.

Payment by an insurance company on behalf of an individual physician for any medical malpractice judgment or settlement, regardless of the amount, is required by law to be reported to
the U.S. Department of Health and Human Services and most state medical licensing boards. The information is kept in the National Practitioner Data Bank (NPDB) and is not available to the general public, but only to state licensing boards, hospitals and other health care entities involved in either discipline, licensing or credentialing peer review. Your state medical licensing board may require disclosure of this information to the public. Your state medical licensing board may also conduct an investigation of the case. You may also be required to report it on any application for privileges, employment, insurance or provider status.

Why is it important to be an active participant in your own defense?

You need to be an active participant in your defense. It is important that your attorney understands what occurred in your own words. He or she is aware of what the plaintiff’s case may be, but is more interested in why you feel the allegations may be without merit and how convincing you are in your explanation of the medicine and your overall demeanor. Malpractice attorneys have experience in the examination of medical records and the litigation process, but are not experts in your field. It is your job, therefore, to medically educate your attorney as to why you feel your care was appropriate and why you believe you have a medically defensible position. Your attorney will also be evaluating how credible and convincing you will be as a witness. Your success or failure with this education process can be the difference between settling the case or proceeding to trial.

How does a claim differ from a lawsuit?

A patient may make a claim (a formal request for payment) directly to your professional liability company prior to, or instead of, filing a lawsuit. Typically, the patient represents themselves, but they may retain an attorney to handle the claims process. Like a lawsuit, the insurance company must be notified immediately. Insurance companies handle claims differently from lawsuits. When a claim is made against an insured, a defense attorney is not usually assigned. Claims are typically handled internally by an insurance company employee, usually a claims specialists or claims attorney. The assigned employee will have the claimant sign a medical records authorization release so the relevant medical records can be collected. Once all of the records have been collected, a review begins.

Professional liability insurance companies review claims on the basis of whether the alleged injury resulted from care that fell below the appropriate standard. Many insurance companies have medical directors who will review a claim in order to determine if there has been a breach of standard of care. If no breach is found, the claim will be denied. If it is determined there was a deviation from the standard of care and the insured physician consents to settlement (where applicable), the insurance company and the claimant engage in negotiations to determine if the claim can be settled. If a settlement amount is agreed upon, the insurance company will have the claimant sign a general release that will prevent the claimant from filing a lawsuit for the same matter. If the settlement of a claim is made on behalf of an individual physician, the settlement must be reported to the NPDB and state medical licensing boards in most jurisdictions.

Expert Witness Selection and Interaction

How are expert witnesses chosen?

A physician or a representative, who is employed by the insurer, will review the medical records and provide an initial impression regarding the allegations of injury, causality and potential breach of the standard of care. The records may then be submitted for review by outside expert reviewers, who will provide verbal input regarding the standard of care and the defensibility of the case. Based on this input, and in consultation with the defendant, a decision will be made whether or not to settle the claim. If it is decided to defend the suit, the reviewer may be asked to serve as an expert witness. Alternatively, the defense counsel 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.

Expert witness selection is not a simple matter and it is an important strategic decision made by the attorney alone or in consultation with the anesthesiologist who is being sued. Experts are chosen based on their known expertise (clinical, publications or both) in the medical area in question in the lawsuit. They may also be chosen because they practice in a clinical setting similar to that of the physician who is being sued. Stated in the form of a question, what would another physician, with the same or similar background, do under the same of similar circumstances? Knowledge of the national standards of practice as well as the local standards and culture are critical to the success of the expert witness whether he or she is working with the defense or the plaintiff attorney.

Ability to explain complex medical concepts in a simple fashion to members of the jury without disrespecting them is a very important skill that the expert witness brings to bear in the entire litigation process. In addition to the teaching the medicine to legal counsel, the expert witness will also teach the medicine to the jury. Therefore, detailed knowledge of the facts of the case, credibility, excellent English communication skills, likeability and ability to remain composed during the high-pressure situations of testimony in court or during depositions are key skills and traits. These skills are as crucial to the mission of the expert witness as are credentials (academic and clinical) as well as prowess.

There are multiple sources (for example, LexisNexis® and Westlaw®) available to insurance carriers, risk managers, plaintiff and defense attorneys. Through these sources, information may be obtained on past opinions and testimonies of expert witnesses. These sites typically charge fees for this information. These sources have assembled large searchable databases comprised of public records, opinions, forms, legal matters, news and business information. In addition to the
database, products and services are provided to a diverse group of professionals including but not restricted to risk management; corporate, governmental, and law enforcement entities; academics; and insurance carriers. Public documents as well as nonpublic documents including past testimonies of expert witnesses may be found in these databases.

The defendant physician must assume an active role in the defense process to include reviewing responses to allegations and interrogatories that suggest breaches of standard of care. It is imperative that the defendant physician review all expert witness testimony. 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.

In summary, the expert witness plays a multifaceted, pivotal role in the entire litigation process. The expert witness will teach “the medicine” to not only the defendant’s legal counsel but also to the jury. The expert witness will review all case materials. It is through this review that the expert witness will ultimately determine the extent to which the physician practiced within the standard of care. It is to this degree that the expert witness will be able to support in the litigation process and the care rendered by the physician.

Deposition

What role do depositions play in the process of a lawsuit?

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 plaintiffs’ 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 plaintiff’s 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 10 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

1. Notice of Lawsuit to Defendant Anesthesiologist

2. Defendant-Private Legal Consultation
   - Settlement Decision Authority
   - Post Trial Implications

3. Conference with Malpractice Carrier

4. Selection of Defense Counsel

5. Anesthesia Care Team Case? Coordination with Other Defense Legal Counsel?

6. Review of Plaintiff’s Expert’s Declaration and Deposition
   Itemized Review of Standards of Care Violations Allegations
   (Review of Other Anesthesia Care Team Staff Alleged Violations)

7. Defendant Response to Plaintiff’s Allegations of Standards of Care Violations
   - Analysis of entire medical record
   - Create running time chart of all significant events/notes
     (before you prepare these materials, discuss with your defense attorney)
   - Create exceptions chart for each event/notes that refutes plaintiff’s allegations
   - Create a list of deposition and additional references that support the defense position

8. Conduct Research of Documents to Support the Standards of Care Issues
   Related to the Defendant Anesthesiologists’ Clinical Decisions Made
   - Utilize the ASA Close Claims Database for similar case review
   - Select pertinent journal articles to support your defense

9. Participate in Case Development Conferences With Your Counsel
   and Your Expert Witness to Understand Their Defense Plan and to
   Reveal All Clinical Issues With Your Patient Management

10. Plan for Your Deposition
    - Plan mock deposition with questions from your expert and counsel on anticipated questions from plaintiff counsel.
      Have your expert compose questions as though he was the plaintiff’s expert against you.
    - Select a day for your deposition free of work activity.
    - Get advance notice of video deposition and encourage a plan for no video deposition.
    - Dress for your deposition as you would for trial! Your potential courtroom demeanor is being assessed!
    - Get specific anger management practice, understanding that plaintiff counsel plans to ask disturbing questions
      and present irritating behavior. Do not lose your temper. Your lawyer will protect you where needed.
    - Use subtle tags to locate all pages you expect to reference in your deposition. Ask counsel to assist.
      Perform review of common deposing attorney questioning behavior designed to promote confusing answers.
      Review techniques with counsel to counteract these adverse questioning techniques.
    - Schedule a deposition day status meeting with defense counsel for last-minute strategy information.
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

Is there some way to end my dispute without a long, drawn out litigation in a court?

The court may encourage procedures for settling the dispute by means other than litigation. The two most popular forms of alternative dispute resolution are mediation and arbitration, although there are others. In some cases, the parties to the dispute may be required to arbitrate based upon previous contractual agreements.

Am I required to participate in mediation, arbitration or settlement?

Many medical services contracts have clauses that require disputes arising from those contracts to be resolved by binding arbitration rather than litigation. This may help the parties keep costs down and keep their disputes private.

Mediation

Mediation is an informal process where an impartial third party, the mediator, helps the disputing parties find a mutually satisfactory solution to their issue. All parties to the dispute must choose and agree upon the person to mediate the dispute. It is helpful to choose a mediator who is experienced in litigating the type of case involved. The mediator guides the parties toward a mutually agreeable settlement by helping them clarify their underlying interests and concerns, and encouraging compromise and trade-offs based on the relative importance of each item to each party. Mediators, however, cannot impose a resolution upon the parties since mediators are not able to make legally binding decisions. All of the writings, discussions and settlement negotiations during mediation are kept confidential. If the parties arrive at a settlement, the details of the settlement “are written down as a contract between the parties and will be binding on the parties.”

Mediation, therefore, is usually well suited to disputing parties who still have a somewhat amicable relationship, who are still able to negotiate, and who do not want a third party to make the final decisions.

Arbitration

Judicial arbitration is a procedure whereby two or more parties agree to have an unbiased, neutral third party (or third parties) act as judge and jury to resolve their dispute for them in private and outside of the public judicial system. An arbitration is a simplified version of a trial that involves less complicated rules and procedures. Arbitrators have more flexibility than court judges to decide what weight to give to the evidence and how the arbitration will proceed. After giving each party the opportunity to present their side of the story and to present any relevant documents or other evidence, the arbitrator decides what the resolution will be.

How are arbitration and binding arbitration different?

If the parties agree in advance to binding arbitration, the decision of the arbitrators will be enforceable in a court of law if the losing party does not comply with the terms of the decision. Binding arbitration, therefore, is more comparable to litigation than is mediation. One important distinction between arbitration and litigation is that the former offers only a very limited right of appeal after a decision is made by an arbitrator whereas litigation with a trial offers a wider variety of options for appealing the decision.

Settlement

If the parties to the dispute arrive at a compromise through mediation, the settlement will be written down as a contract between the parties. The judge in litigation may also order a mandatory settlement conference prior to trial. Typically, mandatory settlement conferences are presided over by a different judge other than the one assigned to the trial.

Court Appearance

If the parties cannot reach a settlement either through mediation or during the mandatory settlement conference, the case will proceed to trial. The jurisdiction in which the case is tried and the composition of the jury may influence the outcome of the trial so only those cases where both sides believe their case is strong typically proceed to a jury trial. Factors such as the appearance, professional behavior, and communication skills of the anesthesiologist as well as the degree of injury to the patient may also influence the outcome of the trial. The defendant anesthesiologist is required to be present during the trial even though he or she may not be called upon to testify.

If the anesthesiologist is called to testify, he or she should carefully review his or her deposition prior to giving testimony; should avoid using complex medical terms that may not be understood by a lay audience; and should explain everything in terms so that the jury will be able to fully understand.

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

How successful are filing of countersuits in protecting the reputation of the anesthesiologist?

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 filling 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 on Physicians and Their Families

Why are anesthesiologists considered second victims when an adverse outcome occurs?

Personal Impact

For most physicians, litigation is a life trauma that can have a significant personal and emotional impact.54,55,56,57 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.58,59 The psychological consequences, however, can persist long after the litigation process has concluded.57,60,61 Afflictions following the process include depression, adjustment disorder, post-traumatic stress disorder and substance abuse. Due to the issue that this stress may impact a physician’s personal and professional life, they become the second victim.62

Professional Impact

The legal process creates a challenge to physicians’ professional identities and practices.54,63,64 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.60,65 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.”66

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.67 Although not immediately obvious, the physician’s spouse experiences similar psychosocial stresses to the physician. These include loss, isolation, vulnerability and social awkwardness.68 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.

What are some treatment options for second victims?

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.60,69

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.55,60,70 Sources of assistance can include family, clergy/spiritual leader, 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.57 Posttraumatic stress disorder (PTSD), suicidal ideations or depression are some of the psychological issues that may occur. The anesthesiologist benefits greatly from addressing and resolving the psychological conflicts associated with the litigation process.61 Further, optimal psychological tools for managing the accompanying stress potentially improve the litigation outcome.70 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. Prolonged exposure therapy or cognitive behavioral therapy are treatment plans used for PTSD.71 From a legal perspective, allow your attorney and malpractice provider to be a resource.55 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 well 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 including 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. Treat yourself as you would your patients and obtain professional support. Seek the assistance from organizations such as the Medically Induced Trauma Support Services (MITSS) whose mission is to support healing and restore hope to patients, families and clinicians affected by adverse events.

In summary, litigation is a highly stressful event for physicians and their families from a number of perspectives. Physicians will benefit from appropriate education and understanding. As such, chose to be an active participant in your personal defense and psychological wellbeing.

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 million/$3 million which indicates that expenses and losses are covered up to $1 million per claim and up to $3 million for all claims over the policy year.

What are the differences between occurrence and claims made policy coverage?

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.

How much liability coverage is typical for anesthesiologists to purchase?

In some states, coverage in excess of primary policy limits is available, usually in the amount of $1 million/$3 million bringing the physician’s total coverage to $2 million/$6 million. This additional or second layer of coverage may be purchased by the individual physician or may be funded by some states or health care 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 health care 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. Physicians choosing not to settle when their insurer has decided to should also be
aware of the “hammer clause” included in some policies. This clause makes the physician responsible for payment of any damage award amount in excess of that the insurer would have negotiated with the plaintiff through settlement. 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 in which physicians are most familiar. As more physicians assume leadership responsibilities within their practices, health care 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. 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.

Are residents in training liable for negligent acts during their anesthesia residency?

There are over 450 separate 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.

Are attending anesthesiologists liable for negligent care of patients by residents in training?

Attending anesthesiologists may be liable for injuries caused by residents and fellows. Depending on the extent of control that attending anesthesiologists have over the residents or fellows as well as the benefit gained by the employers of the trainees, the risk of vicarious liability can exist. As an example, private attending anesthesiologists are likely at greater risk of a vicarious liability claim than an anesthesiologist employed by the institution that sponsors the resident or fellow. As a separate and addition source of liability, claims of improper supervision may be brought against attending anesthesiologists.

Two areas of evolving interest include: 1) What constitutes adequate supervision and responsibilities of the on-call attending physician, and 2) how duty hours regulations affect liability and responsibilities of attending physicians and institutions when patient care errors are identified.

Anesthesiologists that work in some federal hospitals and state university training programs may be immune from liable for injuries suffered by patients through negligence. The doctrine of sovereign immunity has traditionally protected the federal, state governments and their agencies from being held liable for torts committed by their employees. While the governmental organizations may be immune through this traditional protection, employees, including physicians, may or may not remain at risk for liability. The Medical Malpractice Liability Immunity Act protects physicians working as federal employees from being held personal liable for their medical care. States vary in abrogating their sovereign immunity and passing on this liability protection to their employees instead. Physicians who are employed in state university programs should inquire with their human resources and legal departments to determine whether they remain at risk to be a party to liability for medical negligence.

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.

What should those in anesthesia resident program leadership be aware of?

Physicians who serve in leadership positions, as residency or fellowship program directors or as chairs/chefs 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
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.

ASA Closed Claims Project

What is the Anesthesia Closed Claims Project?

The Anesthesia Closed Claims Project began 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 that these associated factors can be modified or eliminated, and reduce the incidence of these injuries, thereby reducing medicolegal liability.

Where does the data come from and what is collected?

The Anesthesia Closed Claims Project works with a panel of professional liability insurance companies from across the country that allow trained on-site ASA members access to their closed claims files. The participating companies insure approximately one-third of practicing anesthesiologists in the United States. Claims are reviewed using a detailed data collection form to collect information on the year of event, patient characteristics, procedure, 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. Claims for damage to teeth or dentures, one of the most common anesthetic complications, are not included in the database. Data is aggregated in a secure centralized database at the Anesthesia Quality Institute (AQI).

What has data shown?

The Anesthesia 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 Anesthesia Closed Claims Database decreased from 56 percent in 1975 to 27 percent in 2000. Consequently, malpractice premiums for anesthesiologists have dramatically decreased from a national average of $41,000 in 1985 to $17,000 in 2017. Data is analyzed for trends over time and complications associated with specific patient or procedural groups, specific types of events or complications, or factors associated with adverse events.
Brief and limited data analyses on specific topics that have not been published may be requested by ASA members through the data request service (see the Anesthesia Closed Claims Project website [www.asaclosedclaims.org](http://www.asaclosedclaims.org) for information on the data request service).

The current Anesthesia Closed Claims Project Database contains 11,036 claims collected through 2016. Of these, 1,567 claims are associated with events that occurred during the last 10 years (2005-2014). Claims for events during surgical anesthesia or procedures are most common (64 percent). Claims arising from pain medicine (management of chronic pain) account for 17 percent, with the remainder arising from acute pain management (9 percent), obstetric anesthesia (8 percent), and critical care or resuscitation (1 percent).

Death remains the most common complication in anesthesia claims, accounting for 30 percent of claims during the most recent 10 years (Figure 3). The other most common outcomes are nerve injury (21 percent), permanent brain damage (9 percent), and airway or esophageal injury (7 percent). Other common complications include burns, emotional distress, injury to the eyes or visual pathways, aspiration pneumonitis, and newborn injury. Nearly half of all claims from this time period involve temporary or non-disabling injuries (44 percent). Permanent disabling injuries (most commonly nerve injury or brain injury) account for 26 percent and death 30 percent.

**Special Considerations for Social Media**

**What are common social media sites used by anesthesiologists?**

Social media is a powerful tool for physicians and patients. Physicians often participate personally and professionally on sites such as Facebook, Twitter and Instagram. Physicians should know the challenges and pitfalls to be aware of.

**What risks are associated with social media use?**

The common risks involve posting patient information that violate HIPAA rules. Any information with personal identifiers should be avoided. The common risks involve posting patient information that violate HIPAA rules. Any information with personal identifiers should be avoided. In addition, during patient care, posting can be particularly concerning if there is some adverse event. There are cases where these have resulted in lawsuits. State laws vary, so risks also depend on location.

**What advice and suggestions are there for using social media in the setting of anesthesia and perioperative medicine?**

Ensure information is accurate and make it clear that it is general medical information and not about a specific patient. Creating fictionalized cases for your social media is preferable to avoid any misunderstandings. Avoid publishing information that could violate HIPAA. Next, consider the time of your post and delay posting if one is participating in active patient care.

**What case samples are there regarding social media use in medicine?**

Some particularly complex cases may occur. First, avoid posting texts that another doctor sends you if it contains HIPAA information. The doctor posting the information may be liable despite not being the original creator of the text. For communication between physicians, use of institution specific secure physician portals is increasing. Next, doctors are not anonymous in their patient care. Patients may post information about their medical care including doctor’s names.

**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.
References:


56. File AE. My malpractice case was literally tried by fire. Med Econ. 2001;78(6):57-58, 61.


