# 10 Anesthesiology

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## SUMMARY

This chapter reviews the leading causes for anesthesiology malpractice claims and the indemnity payments that result from different patient injuries. Risk-management strategies are provided both to help prevent patient injuries and to make anesthesia claims more defensible. The effect of anesthesia claims on the physician is discussed.

**Key Words:** Anesthesiology; American Society of Anesthesiologists (ASA) monitoring standards; frequency; severity; claims trends; informed consent.

## INTRODUCTION

In the 20 years since the widespread adoption of new monitoring technologies in anesthesia, the specialty has gone from high to low risk in the rating systems of most malpractice carriers. It is often cited as a role model for specialties seeking to improve patient outcomes and decrease the likelihood of malpractice litigation. Anesthesiology currently has one of the lowest incidences of claim frequency among all specialties, with anesthesiologists sued an average of once every 8 years. The nature of the claims themselves has also changed with a marked decline in the percentages of claims for catastrophic injures

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such as brain damage and death. As a result, in inflation-adjusted dollars, anesthesia is one of the few specialties to see declining premiums.

This decrease in catastrophic cases is largely attributable to the monitoring capabilities supplied by the pulse oximeter and end-tidal carbon dioxide ($CO_2$) monitors. These came into widespread use in the 1990s and are now included in American Society of Anesthesiologists (ASA) monitoring standards. These monitors, when used correctly, have virtually eliminated unrecognized esophageal intubations in the operating room and serve as an early warning sign of inadequate ventilation, something that only 15 years ago, surgeons first recognized by noticing darker blood in the surgical site.

The practice of anesthesiology itself has undergone radical changes in recent years. General anesthesia now includes options of both inhalational (gas) anesthetics and total intravenous agents. Difficult intubations are aided by newer visualization techniques or eliminated by the use of the laryngeal mask airway (LMA). Many cases can now be performed with monitored anesthesia care (MAC; intravenous sedation) or regional neurological block techniques. These newer alternatives have improved patient safety by allowing anesthetics to be specifically tailored to the patient's needs and physical limitations.

Many anesthesiologists now work outside the operating room in intensive care units or as pain specialists in freestanding office practices. By working in these areas, anesthesiologists have overlapped the traditional practices of family practitioners, physical medicine physicians, and neurologists, among others. Malpractice insurance companies have had to struggle to assess and appropriately price these new risks and to decide whether these anesthesiologists rightly belong to separate specialties, such as pain or intensive medicine. The discussion of pain and other nontraditional anesthesiology practices is beyond the scope of this chapter, which is intended to focus on claims related to operating room, surgery center, office operating room, and obstetrical anesthesia.

## CLAIMS

To study anesthesia claim trends, The Doctors Company (TDC), a national physician-owned medical malpractice insurance company, looked at a representative sample of 500 consecutive anesthesia claims. Of the 500 claims, 456 had closed at the time of the review. Of the closed claims, 51 (11%) resulted in indemnity payments. Malpractice indemnity, by definition, is a dollar payout on behalf of the phy-