Failure to adequately assess patient

by Wendy Kaliszewski, risk management representative

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely to emphasize the issues of the case.

Presentation

A 65-year-old woman came to her cardiovascular surgeon to follow up on her coronary artery disease. The surgeon found that she had a 90% occlusion of the left carotid artery. He scheduled her for a carotid endarterectomy. The patient’s medical history included juvenile rheumatoid arthritis, coronary artery disease, hypertension, hypercholesterolemia, and peripheral arterial occlusive disease.

Her surgical history included spinal stenosis, angioplasty with stent placement in the proximal left anterior descending coronary artery, stent placement in the renal artery, laparoscopic cholecystectomy, hysterectomy, bilateral hip arthroplasty, and bilateral knee fusion. She had experienced a failed intubation that required a tracheostomy during the bilateral hip replacement.

At the time of her admission, the patient was taking quinapril, clonidine, atenolol, atorvastatin, ranitidine, zantac, lorazepam, and aspirin.

Physician action

The patient was admitted to the hospital on March 18 for surgical correction of a 90% stenosis of the left carotid artery. The patient had been evaluated and cleared for surgery by the cardiologist. The anesthesiologist saw the patient 10 minutes before taking her into the operating room. He documented that the patient was 4-feet, 8-inches tall and weighed 155 pounds. She had severe arthritis and the history/physical exam report stated that the patient had limited movement in her arms and neck. The record also reports that she had a very difficult mouth opening. A peripheral IV catheter and a right radial arterial catheter were placed.

In the operating room, the patient was pre-oxygenated, and general anesthesia was induced. The patient received intravenous benzodiazepine, narcotic and sedative/hypnotic agents, volatile anesthetic, but no muscle relaxants. The anesthesiologist attempted to place a Fastrach intubating LMA, but was unsuccessful. While the patient continued to breathe spontaneously, flexible fiber optic intubation was attempted, but unsuccessful. A #3 LMA was placed at that time. Frothy secretions consistent with pulmonary edema were noted, and intravenous medications (nipride, lasix) were given.

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The anesthesiologist requested assistance from another anesthesiologist and a pulmonologist. Further intubation attempts by these physicians were also unsuccessful, including fiber optic and trans tracheal techniques. A trauma surgeon placed a surgical tracheostomy.

The patient’s recorded peripheral oxygen saturation was in the 80s to 90s throughout the course, except one recorded saturation of 68%. The surgical case was cancelled and the patient was taken to the ICU and placed on a ventilator. She was kept on a ventilator for approximately one month until she was eventually weaned from the ventilator and discharged on April 25.

Allegations
A lawsuit was filed against the anesthesiologist. Allegations included negligence in not reviewing the patient’s prior anesthesia records before the surgery. Had he done so, he would have realized that this patient had a history of difficult intubations and additional precautions could have been considered. The plaintiffs claimed that he should have performed an awake fiber optic intubation due to the patient’s difficult airway. It was further alleged that the anesthesiologist’s negligence caused the patient to undergo a tracheostomy, an extended hospitalization, and rehabilitation.

Legal implications
The defense experts who reviewed the case could not support the anesthesiologist’s care and agreed with the plaintiff’s experts. They stated that the defendant failed to adequately assess the patient pre-operatively; failed to examine her; failed to assess her difficult airway; failed to review her medical records; and failed to formulate an appropriate anesthetic plan. He performed general anesthesia before securing her airway. A better choice was a fiber optic intubation while the patient was awake.

Risk management considerations
The American Society of Anesthesiologists (ASA) recommends that “an airway physical examination should be conducted, whenever feasible, prior to the initiation of anesthetic care and airway management in all patients. The intent of this examination is to detect physical characteristics that may indicate the presence of a difficult airway. Multiple airway features should be assessed.” 1

The documented physical exam for the patient was very brief and the anesthesiologist admitted that he spent only 10 minutes with the patient preoperatively. Had he conducted a proper physical exam, he would have seen the tracheostomy scar, which would have indicated that the patient had a prior issue with anesthesia. This may have prompted him to question the patient more about her anesthesia history or request her previous anesthesia records so that he could formulate an appropriate anesthesia plan.

It is also important to obtain a proper airway history from the patient. This helps to detect medical, surgical, and anesthetic factors that may indicate the presence of a difficult airway. The ASA has set up a “Difficult Airway Algorithm” that provides guidance when dealing with a difficult airway. 1 Many of the consultants were critical of the anesthesiologist’s decision to intubate after the induction of general anesthesia instead of attempting an awake intubation.

Disposition
This case was settled on behalf of the anesthesiologist.

Source

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Policyholders must enroll in Trust Rewards to create their account. Enrollment kits were mailed in early January. Policyholders can also complete an enrollment form at www.tmlt.org/trustrewards.

Eligibility

The Trust Rewards Program is designed to reward policyholders who have demonstrated loyalty to the Trust and a commitment to practicing quality medicine.

All full-time and part-time physician policyholders who are insured on December 31 of the previous year and who enroll in the program are eligible. New policyholders who sign up when their coverage goes into effect are also eligible. Physicians who are not eligible are those insured on a scheduled physician policy, physicians rated on a “per patient” or “per encounter” basis, and entities.

Funding

The TMLT Board of Trustees will determine funding for Trust Rewards annually, based on the financial performance of the Trust. If an amount is allocated, a policyholder’s share will be based on that policyholder’s earned premium for the past 3 calendar years as it compares to the overall earned premium for all policyholders.

Pay-out and forfeitures

Participating physicians are eligible for pay-out upon their retirement on or after age 50 and 3 years of coverage with TMLT; upon death; or upon a qualifying disability. In all other cases — including non-renewal of coverage by TMLT — the funds will be forfeited. Requests for pay-out must be in writing. Pay-out will be in the form of a lump sum. Periodic payments or annuities are not permitted. All contributions are tax-deferred until distributed. All taxes are the responsibility of the recipient and will not be withheld by TMLT at the time of the distribution.

Ownership

The TMLT Trust Rewards Program is a benefit established for individual insured TMLT physicians and is maintained in the physician’s name. If a physician changes groups or starts a solo practice, there is no impact on the program, as long as the physician maintains medical professional liability coverage with TMLT. Some physicians may prefer that the proceeds from the Trust Rewards Program be paid to a practice group or entity instead of to the individual physician. This is permitted if the physician assigns the balance of the account to the group. However, the group would only receive the funds if the physician retires, passes away, or becomes disabled while employed by or associated with the group.

Additional information

The terms and conditions of the TMLT Trust Rewards Program are governed by the Plan Document adopted by the Board of Trustees of Texas Medical Liability Trust. If any information, comments or statements in this article, or in any other document or communication — including press releases, letters and electronic information conflicts with the Plan Document — the Plan Document shall supersede such information, comments, or statements.

Any funds made available for the benefit of the Trust Rewards Accounts shall be unrestricted surplus of TMLT until and unless distributed to the participant and, as such, remain available to TMLT for the satisfaction of policyholder obligations and general creditors. No participant shall have any individual claim to any funds made available for the benefit of the Trust Rewards Accounts until and unless such funds are distributed to the participant.

For more information on Trust Rewards, please visit www.tmlt.org/trustrewards or contact TMLT Customer Service at 800-580-8658 ext. 5050.

TMLT adds cyber liability coverage to all policies

Physicians and medical groups are increasingly at risk for privacy-related claims that occur as a result of lost laptops, theft of hardware or data, improper disposal of medical records, hacking or virus attacks, and rogue employees. Our new cyber liability coverage offers protection for network security and privacy-related exposures faced by medical professionals, including:

- Network security and privacy insurance — coverage for both electronic and physical information, virus attacks, hackers, identity theft, and defense costs for regulatory proceedings.
- Regulatory fines and penalties insurance — coverage for administrative fines and penalties a policyholder may be required to pay as the result of an investigation conducted by a federal, state, or local government agency resulting from a privacy breach (such as HIPAA, HITECH, and state or federal notification requirements).
- Patient notification and credit monitoring cost insurance — includes all necessary legal, IT forensic, public relations, advertising, call center, and postage expenses incurred by the policyholder to notify third parties about the breach of information. This coverage will also pay for credit monitoring for all affected parties.

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- Data recovery costs insurance — includes all reasonable and necessary costs to recover and/or replace data that is compromised, damaged, lost, erased, or corrupted.

TMLT’s cyber liability coverage offers annual aggregate limits of $50,000 per insured physician/entity. Increased limits are available for purchase. Please contact your underwriter at 800-580-8658.

Medefense coverage enhanced

All TMLT policies covering individual physicians include our Medefense Endorsement, which provides reimbursement for legal and tax audit expenses for disciplinary proceedings. The endorsement covers the following:

- a review action by the Texas Medical Board (TMB);
- a hospital action regarding clinical privileges;
- actions by the Texas Department of State Health Services or the U.S. Department of Health and Human Services;
- non-compliance with Medicare/Medicaid regulations, to include Recovery Audit Contractor Program;
- proceedings alleging violations of EMTALA, HIPAA, or Stark Laws; and
- federal tax audits.

In 2011, the Medefense endorsement was enhanced to include coverage for payment of civil fines and penalties associated with disciplinary proceedings.

Medefense limits were also increased up to $50,000 per insured event with an annual aggregate limit of $100,000 per policy period.

Medefense benefits are subject to a $1,000 deductible, with a 10% coinsurance provision (the physician will pay 10% of the legal expenses after application of the deductible). TMLT will waive the deductible and coinsurance and pay legal expenses directly if you hire an attorney from a panel provided by TMLT.

The coverage for tax audits will be limited to a $5,000 maximum reimbursement.

To take advantage of Medefense coverage, policyholders should:

- Notify TMLT as soon as you receive the initial letter from the TMB or other disciplinary authority. The policy states that a policyholder has 60 days in which to report an event or letter in order to receive reimbursement for covered expenses.
- Consider retaining an attorney to help draft a narrative and to respond to the disciplinary authority. Upon request, TMLT can provide policyholders with a list of attorneys who have experience handling disciplinary proceedings.