Cheney FW: Committee on Professional Liability: Reflections on 11 years as Chair. *ASA Newsletter* 59(6):6-8, 1995.

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As I step down as the Chair of the Committee on Professional Liability, it is interesting to reflect upon the changes that have occurred during the past decade in the domain of professional liability as it affects the anesthesiologist. Our legal system is still as convoluted as ever, but its impact on the anesthesiologist has changed dramatically.

At the time I assumed the Chair of the committee in October 1984, there was a "crisis of affordability" of professional liability insurance in the United States. This was the second crisis involving professional liability insurance; the first occurred in the mid-1970s when there was a "crisis of availability." By the mid-1980s, anesthesiologists were in the high risk category along with obstetricians and neurosurgeons; professional liability premiums for anesthesiologists were in the $50,000 to $75,000 per annum range in some of the high cost areas.

The ASA membership was extremely concerned about this financial burden and under the leadership of Ellison C. Pierce, Jr., M.D., a concerted effort was launched to improve anesthesia patient safety. The basic philosophy about the best method of avoiding malpractice claims that evolved at the time was that if patients did not have anesthesia-related injuries, they would not sue. Also at this time, ASA created two committees, the Committee on Patient Safety and Risk Management (1984) and the Committee on Standards of Care (1985), and the Anesthesia Patient Safety Foundation was founded (1985). All three entities have had a significant impact on anesthesia patient safety.

The Committee on Professional Liability was charged in this era to develop a strategic plan to address the problem. Two separate and distinct programs were initiated:

1. Development of strategies to deal with the perceived "expert witness" problem.

2. A study to define the anesthesia-related injuries that were causing lawsuits and to develop strategies for their prevention.

There was a widespread perception at the time that expert witness testimony rendered by "liars for hire" was a major contributing factor to the professional liability crisis. It was thought that the availability of testimony about standard of care and causation that did not reflect the majority opinion of the profession at the time was encouraging plaintiff's attorneys to sue and to win meritless cases. The committee's strategy to address this issue was to solicit deposition and trial testimony (which are public record) from members who had been victims of this testimony and publish it in the NEWSLETTER with or without the name of its author.

This initiative ultimately foundered for two reasons. First, testimony that was often perceived as "outrageous" by a defendant anesthesiologist and their lawyer was often not perceived in the same manner by the members of the Expert Witness Subcommittee.

Secondly, the strategy failed because ASA legal counsel imposed strict rules as to what could be published in the NEWSLETTER. In retrospect, this was a correct decision.

Curiously enough, data from the other major initiative, the ASA Closed Claims Project, shed light as to where the real problems lie with expert witness testimony. In a study reported in the Journal of the American Medical Association with an accompanying editorial, Caplan et al.[1] showed that practicing anesthesiologists exhibited a significant degree of outcome bias in making judgments about standards of care. The data were derived from cases in the ASA Closed Claims Project. For a given clinical scenario, if the outcome was bad, the standard of care was significantly more likely to be judged as substandard than if the outcome was a temporary or less severe injury. The conclusion reached from these data was that bonafide experts were influenced by a poor outcome in making their judgments about standard of care; thus, it becomes relatively easier for plaintiff's attorneys to obtain expert testimony when an adverse outcome occurs.

As it turns out, we seem to be our own worst enemies when judging the standard of care. The only substantive accomplishment by the Committee on Professional Liability in the expert witness area was the development of guidelines for expert witness qualifications and testimony, which were approved by the ASA House of Delegates in 1990.

The major accomplishment of the committee in the past decade has been the ASA Closed Claims Project, which was begun with the objective of identifying the etiology of anesthesia-related patient injuries and proposing strategies for their prevention. The database at present contains approximately 3,500 closed claims that have been retrieved from 34 insurance organizations which insure about 14,500 anesthesiologists.

The accumulated data have provided material that resulted in the publication of 13 peer-reviewed articles published mostly in Anesthesiology and JAMA. Four of these publications have been accompanied by editorials. Two papers in particular on spinal cardiac arrest and nerve injury have been utilized extensively by defense attorneys to defend anesthesiologists accused of malpractice in cases where these adverse outcomes occurred without any associated negligence.

Data from the Closed Claims Project have played a significant role in the development of recommendations from the ASA Committee on Standards of Care (i.e., oximetry, capnography) and the decision of the ad hoc Committee on Practice Parameters to formulate guidelines for management of the difficult airway.

An offshoot of the Closed Claims Project is the initiation of a program with the American Academy of Pediatric Perioperative Cardiac Arrest Registry (page 13). The objective of this registry is to track pediatric cardiac arrests and deaths that occur during anesthesia. The intent is to gain insights as to why highly unfavorable outcomes occur. The need for this type of in-depth analysis came to light through analysis of pediatric claims in the Closed Claims Project database.

The Closed claims Project as currently structured is an effective organization for ongoing retrieval, review and dissemination of information on anesthetic injury. It represents a national quality assurance system that encompasses the experience of more than 50

percent of the practicing anesthesiologists in the United States. The Closed Claims Project represents a distinctive U.S. contribution to the study of anesthetic injury, and as such, it commands considerable interest in the international anesthesia community as a source of unique information and a model for inquiry.

Professional liability rates for anesthesiologists have dramatically decreased over the last decade. For example, the premium for a standard claims made policy for an anesthesiologist in Washington state has decreased from about $27,000 in 1984 to about $11,000 today, a reduction of more than half, even without accounting for inflation.

The question may arise as to why the project continues. One reason is that the ongoing data collection provides an opportunity for analyzing and understanding rare injuries. For example, a report last year in Anesthesiology on burns resulted when a request for information was processed and a significant number of burns were found to result from I.V. fluid bags warmed in an oven. Since burns from this source had not been reported previously, we took the opportunity to warn the practicing community of this potential hazard.

Another example of the usefulness of the database is that it can counter bureaucratic "conventional wisdom". Recently, consultants from the Joint Commission on Accreditation of Healthcare Organizations insisted that the Department of Anesthesiology at the University of Washington Medical Center have a separate signed consent for anesthesia. The rational given by the consultants was that this was an important issue in reducing liability exposure for anesthesiologists. When we surveyed the Closed Claims database, we found that informed consent is essentially a nonissue as far as liability for the anesthesiologist. This information is presented in this issue of the NEWSLETTER in an article by Robert A. Caplan, M..D. and Karen L. Posner, Ph.D. (page 9), which the committee hopes will serve others as an effective counterpoint to such unsubstantiated bureaucratic thinking.

Another rationale for ongoing data collection is to document how changes in practice engendered by ASA monitoring standards and the airway practice guideline have actually affected patterns or trends in patient injury and liability. Based upon currently discernible trends in the database, the number of respiratory-related injuries and high severity injuries seems to be decreasing, which is good news as far as controlling the costs of professional liability insurance.

The Closed Claims Project provides a rigorous mechanism for studying the liability experience of practicing U.S. anesthesiologists. Nearly a decade of experience demonstrates that the data obtained can reveal important and previously unappreciated aspects of adverse anesthetic outcomes. These insights can be used to identify strategies for improving the quality of anesthesia care, thus providing a powerful tool for advancing patient safety and sustaining reductions in premiums for professional liability insurance.

Times have changed dramatically in that professional liability is no longer a dominant issue for the anesthesiologist. Now some of the major problems facing ASA are those of reimbursement, physician resources and managed care. Let us hope that the strategies initiated by ASA in 1995 to deal with these issues will be as successful as those initiated in 1985 to combat the professional liability "crisis".

Reference

1. Caplan RA, Posner KL, Cheney FW. Effect of outcome on physician judgments of appropriateness of care. JAMA. 1991; 265:1956-1960. [Abstract]

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