Fitzgibbon, DR: Liability Arising From Anesthesiology-Based Pain Management in the Nonoperative Setting. *ASA Newsletter* 65(6): 12-15, 2001.

Full Text

A nesthesiologists traditionally have been at the fore-front in the management of both acute and chronic pain by providing the principal leadership in development of the practice of pain medicine. 1 Anesthesia-based chron-ic pain medicine typically involves patient evaluation, pro-vision and interpretation of diagnostic procedures, clinical pharmacology, provision of alternative drug delivery meth-ods, provision of temporary or long-term neural blockade and provision of neuromodulatory techniques. Chronic pain management techniques aim to optimize pain control, mini-mize adverse outcomes, enhance functional abilities with favorable physical and psychological outcomes and enhance the overall quality of life for patients with chronic pain.

In order to assess the liability associated with the prac-tice of nonoperative pain management, we examined the ASA Closed Claims Project database for related injuries occurring between 1970 and 1998. Only claims related to pain management by anesthesiologists in the nonoperative setting (nonacute pain) were considered. Pain management claims were grouped as procedures (blocks and interven-tions) and miscellaneous care ("medication management," "other" and "opinion only").

A total of 241 out of 5,480 (4.4 percent) claims in the database were for pain management in the nonoperative setting. The relative proportion of pain claims to all claims increased over time. Pain management claims accounted for 8 percent of all claims in the 1990s, compared to 2.76 percent in the 1980s and 1.95 percent in the 1970s [Figure 1]. Anesthesia procedures (blocks and interventions) accounted for 98 percent (236 of 241 claims) of pain man-agement claims, with anesthetic blocks accounting for 84 percent of claims [Figure 2]. A breakdown of the specific blocks, interventions and miscellaneous pain management techniques found in the claims is provided in Table 1.

Figure 1: Pain Management in the Nonoperative Setting

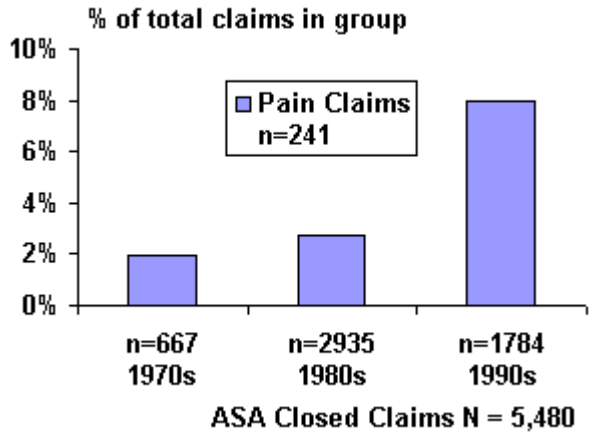
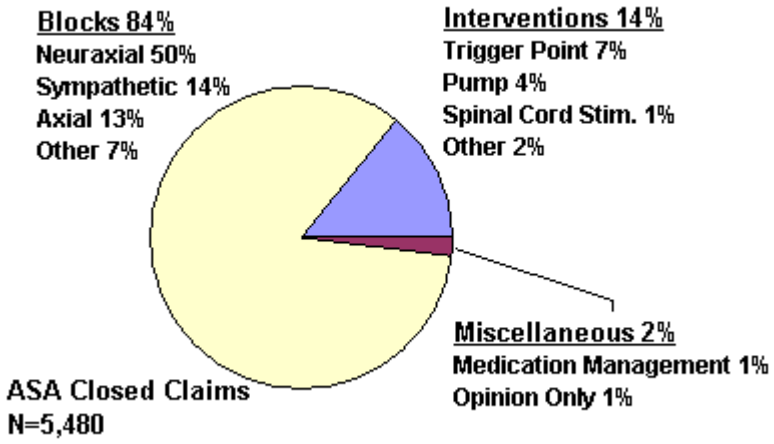


Table 1: Number of Claims Related to Blocks, Interventions and Miscellaneous Management Care Issues

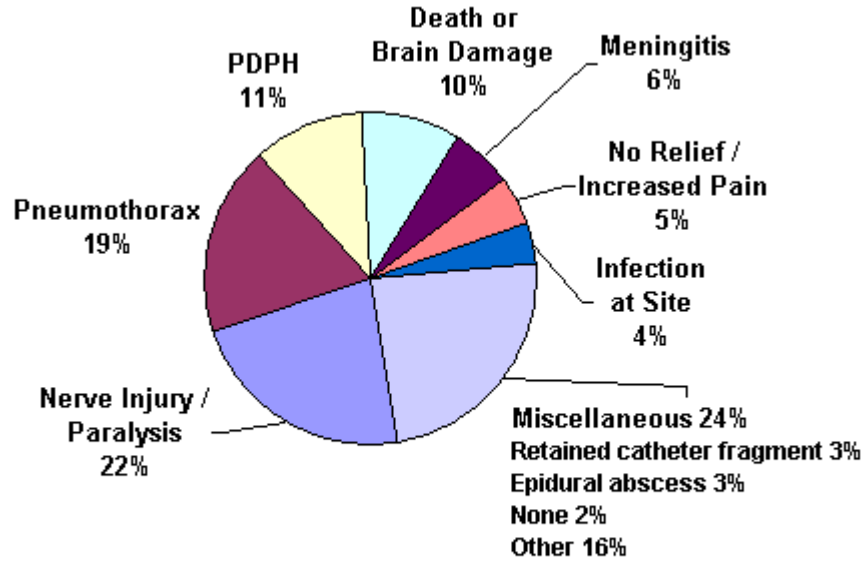
Pain Management	# claims	% of 241
Blocks	202	84%
Neuraxial Block	120	50%
Sympathetic Block	33	14%
Axial Nerve Block	31	13%
Other Blocks	18	7%
Interventions	29	12%
Trigger Point Injection	16	7%
Pump Insertion or Refill	10	4%
Spinal Cord Stimulator	3	1%
Miscellaneous	10	4%
Other	5	2%
Medical Management	3	1%
Opinion Only	2	1%

Figure 2: Anesthesia Procedures and Miscellaneous Management Claims (n=214)



The most common adverse outcome from anesthesia blocks were nerve injury or paralysis/paraplegia (23 per-cent), pneumothorax (19 percent), postdural puncture headache (PDPH) (11 percent), death or brain damage (10 percent), meningitis (6 percent), no pain relief or increased pain (5 percent) and infection at the injection site (4 per-cent) [Figure 3].

Figure 3: Injuries Associated with Anesthesia Blocks (n=202)



Of the anesthesia block claims, 120 (55 percent) were for neuraxial (epidural, intrathecal) blocks, 78 percent of which (93 of the 120 claims) were associated with injection of steroids or combination of agents (opioids, local anesthetics) with steroids into the epidural space. Adverse events associated with the use of epidural steroids (or asso-ciated agents) included PDPH (23 percent), nerve injury or paralysis/paraplegia (22 percent), meningitis (11 percent), death or brain damage (11 percent), no relief or increased pain (9 percent), infection at the injection site (6 percent) and epidural abscess (4 percent) [Figure 4]. Care in the management of epidural steroid-related complications was deemed substandard in 30 percent and impossible to assess in 19 percent. Payment was made in 43 percent of epidural steroid-related claims. The median payment in these cases was $27,500 with a range of $2,000-$1,812,500. Substan-dard care claims were more likely to be paid than standard care claims (79 percent versus 19 percent, $p < 0.05$) [Tables 2 and 3].

Figure 4: Injuries Associated with Epidural Steriods and Associated Agents (n=93)

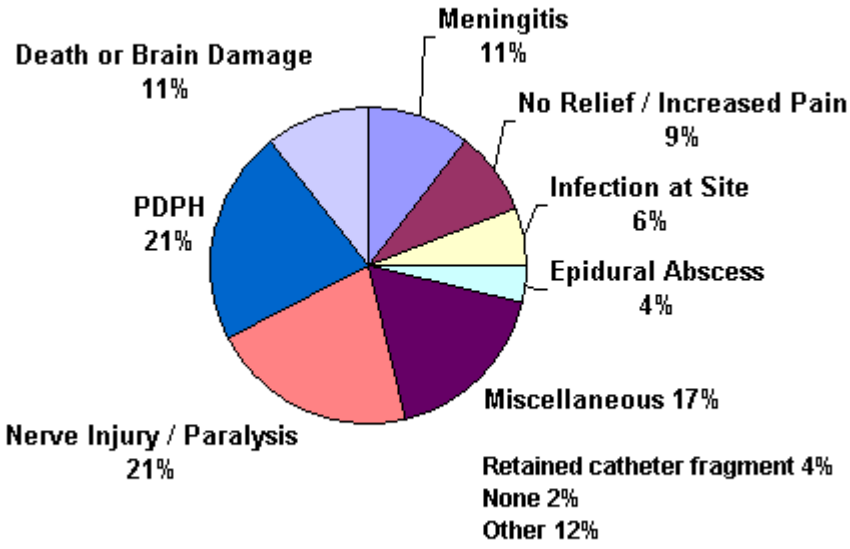


Table 2: Number of Claims, Number of Payments, Number of Cases Deemed as Substandard in Care and Median Payment Amount in Dollars for Anesthesia Blocks

Type of Block #	# (n=202)	# Substandard Care	# Cases Receiving Compensation	Median Payment
Neuraxial	120	40	56	38,000
Sympathetic	33	9	18	30,000
Axial	31	7	16	7,000
Upper Extremity	7	2	3	25,000
Lower Extemity	2	2	1	15,000
Head or Neck	4	2	3	1 million
Other	5	2	1	2,000

Table 3: Number of Claims, Number of Payments, Number of Cases Deemed as Substandard in Care and Medican Payment Amount in Dollars for Anesthesia Interventions and Miscellaneous Care Issues

Type of Block #	# (n=37)	# Substandard Care	# Cases Receiving Compensation	Median Payment
Trigger Point	16	5	11	20,000
Pump Insertion	8	3	5	60,000
Pump Refill	2	2	2	889,000
Spinal Cord Stimulator	3	0	1	25,000
Medication	3	1	3	15,000
Sedation for procedures	1	0	0	0
Other	4	1	3	250,000

Anesthesia blocks account for the majority of profes-sional liability claims for nonoperative pain management. The majority of neuraxial block claims involved injection of epidural steroids and associated agents. Compensatory payments were made in a substantial number of epidural steroid-related claims associated with substandard care. Clearly the practice of nonoperative pain management has the potential for patient injury and presents an increasing liability hazard for the anesthesiologist.

References

1. Practice Guidelines for Chronic Pain Management. A report by the American Society of Anesthesiologists Task Force on Pain Management, Chronic Pain Section. Anesthesiology. 1997; 86:995-1004.

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