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Professional Liability: What's Ahead?

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Historians tell us that the future is best understood by studying the past. This may be good advice when it comes to understanding the challenges that lie ahead of us in professional liability.

The insurance industry provides a good barometer for recent trends. In the early 1980s, the relative risk rating for anesthesiology was in the range of 4 to 6, which is comparable to ratings for neurosurgery and cardiovascular surgery. (The relative risk rating is used to apportion insurance premiums according to the magnitude of loss in each specialty -- the higher the relative rating, the higher the cost of the insurance premium.)

Beginning in the late 1980s, insurance losses associated with anesthesia care showed such a significant and persistent decrease that the relative risk rating for anesthesiology was lowered. These trends have been sustained, and today, the relative risk rating for anesthesiology is in the range of 2 to 3, which is comparable to ratings for nonsurgical specialties. Such changes translate into substantial savings for the practitioner. In Washington state, the premium for a standard "claims made" policy in 1984 was about $27,000. Today, a comparable premium (without adjusting for inflation) costs about $11,000.

What set these changes in motion? In the early 1980s, ASA adopted a simple but far-reaching philosophy: the best method for controlling the cost of professional liability is the *prevention* of injuries. The reasoning behind this philosophy is straightforward. If injuries are fewer and less severe, then there will be fewer claims and malpractice lawsuits. If there are fewer claims and malpractice lawsuits, insurance losses will be lower and premiums will decrease. Because the expense of premiums and adverse outcomes is passed along, at least in part, to the consumer and third-party payer, this strategy has the potential to make a broad contribution to the cost-effectiveness of anesthesia care.

To put this philosophy to work, ASA initiated a variety of projects. The general goal was to find ways to promote and improve the safety of anesthesia. In aggregate, these efforts are sometimes called "the anesthesia patient safety movement." One of the most important leaders of this movement, Ellison C. Pierce, Jr., M.D., reviewed the history of anesthesia patient safety in the 34th Annual Rovenstine Memorial Lecture at the 1995 ASA Annual Meeting. This lecture will be published in a forthcoming issue of the journal *Anesthesiology,* and it is sure to make fascinating reading.

For the past decade, the Committee on Professional Liability has been an active participant in the patient safety movement. This role takes the form of the ASA Closed Claims Project. In keeping with the basic philosophy that prevention of adverse outcomes is the best method for controlling the costs of professional liability, the goal of the Closed Claims Project is to discover unappreciated patterns in anesthesia care that may contribute to patient injury and subsequent litigation. The detection of such patterns can serve as an effective tool for directing patient safety research and devising new preventive strategies.

The usefulness of closed claims data was first appreciated in the early 1980s by Richard J. Ward, M.D., Professor of Anesthesiology, University of Washington, and Richard J. Solazzi, M.D., then an anesthesiology resident at the University of Washington, Seattle. In the process of studying closed

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malpractice claims against anesthesiologists in Washington state, Drs. Ward and Solazzi realized that these cases provided an enriched environment for collecting detailed information about rare but often catastrophic events. They also realized that the opportunity to collect a *relatively large* set of rare events might reveal recurring themes and insights that would be difficult to discern by the practitioners who experienced the cases as *isolated* events.

In 1984, Dr. Ward convinced Dr. Pierce, who was then the President of ASA, that a *nationwide* effort would be the best way to realize the potential benefits of closed claims analysis. Dr. Pierce agreed, and the Closed Claims Project was assigned in 1985 to Frederick W. Cheney, M.D., then Chair of the Committee on Professional Liability.

Insurance companies were initially reluctant to have closed claims reviewed by outside physicians. After a slow start in the mid-1980s, the project gained wider acceptance, and the number of participants steadily increased. Today, closed claims are obtained from 35 U.S. insurance carriers. On aggregate, these carriers provide coverage for approximately 50 percent of practicing anesthesiologists in the United States. The current database contains more than 3,500 claims and represents the world's largest single resource for the in-depth study of major adverse outcomes related to anesthetic practice.

Since the inception of the Closed Claims Project, 13 papers have been published in peer-reviewed literature. Most of the publications have appeared in the journal *Anesthesiology.* Four papers have been accompanied by editorials. The papers cover a broad range of topics, including new mechanisms of anesthesia-related injury, liability patterns and how anesthesiologists make decisions about the standard of care.

Findings from the Closed Claims Project have played an important role in shaping the features of ASA standards and guidelines, particularly those that relate to the use of pulse oximetry in the operating room and recovery room, the use of capnography for verification of endotracheal tube location and the role of guidelines in the management of the difficult airway.[1-3]

Sixty-one ASA members currently serve as reviewers for the Closed Claims Project. The Society owes a great deal of thanks to these members, who devote many long hours to the task of claims review, often at sites distant from home. Current reviewers are acknowledged on the Committee on Professional Liability membership list.

Leadership of the Closed Claims Project remains with Dr. Cheney at the University of Washington. As Director, Dr. Cheney is assisted by Associate Directors Robert A. Caplan, M.D., and Karen B. Domino, M.D.; Project Coordinator Karen L. Posner, Ph.D.; a research assistant; and a secretary.

Although the project has grown considerably in size, it remains efficient and cost-effective. Funding for the project is provided entirely by the ASA membership. Expenses in 1995 were $124,928. Most operating costs are associated with salaries for nonphysician support staff, database management and reimbursement for reviewers' travel to insurance companies. Physician participation remains entirely voluntary and uncompensated.

What's Ahead?

The recent stream of cases entering the Closed Claims Project suggests that the landscape of liability in anesthesiology is changing. Happily, the change continues in a favorable direction. As reported by Dr. Cheney in this issue of the *NEWSLETTER* [see page 10], the percentage of claims for death and brain damage continues to decrease -- from 56 percent in the 1970s, to 45 percent in the 1980s, to 31 percent thus far in the 1990s. A similar pattern emerges for claims involving adverse respiratory events. These and other patterns described by Dr. Cheney suggest that the Closed Claims Project may offer a valuable way to assess the impact of changes in practice such as monitoring standards and guidelines. In this way, the Closed Claims Project may be able to serve as an ongoing nationwide monitor of quality assurance in anesthesiology.

Under the direction of Dr. Posner, the scientific and technical aspects of data collection and analysis continue to evolve. The resources of the Closed Claims Project are now developed well enough that they can be "exported" for use in related areas of inquiry. The articles in this issue of the *NEWSLETTER* by T. Andrew Bowdle, M.D., Ph.D., [see page 22] and Karen B. Domino, M.D., [see page 14] provide excellent examples of how the database of the Closed Claims Project can be used to explore a specific area of clinical concern. In particular, these articles demonstrate how closed claims data can be used to support and extend observations from conventional sources such as case reports and clinical reviews.

Another example of an "export product" from the Closed Claims Project is the Pediatric Perioperative

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Cardiac Arrest (POCA) Registry. This registry is directed by Jeffrey P. Morray, M.D., and Jeremy M. Geiduschek, M.D., of the Children's Hospital and Medical Center, Seattle, Washington. Support and guidance for the POCA Registry is provided by the staff of the Closed Claims Project.

Preliminary findings from the POCA Registry are described in this issue of the *NEWSLETTER* by Dr. Morray [see page 26]. Unlike the Closed Claims Project, the POCA Registry obtains cases directly from anesthesiologists associated with the practice settings where the adverse events actually occur. This means that there is less likelihood that data of interest will be inaccessible. In addition, there may be relatively little delay between the occurrence of an adverse event and its entry into the POCA database. (In contrast, the legal process often interposes a delay of several years between the occurrence of an adverse outcome and its "availability" as a closed claim.) Of special interest, the POCA Registry includes a mechanism for follow-up reports and retrieval of missing information; thus, the POCA Registry incorporates innovations in data collection that may lead to insights that cannot be discerned from closed claims data.

The POCA registry provides groundwork for applying the techniques of closed claims analysis to the study of insurance company incident reports. Incident reports may be an important resource for the future study and management of professional liability because this type of information is much more contemporaneous than closed claims data. In this way, the study of insurance company incident reports may provide a means for the Closed Claims Project to act as an "early warning system" that can improve our ability to identify emerging problems and implement timely remedies. Early warning systems may be especially important as we enter an era of health care that is increasingly dependent upon cost controls.

What lies ahead for the Committee on Professional Liability? If the past does indeed provide us with clues, then the future directions are not too difficult to identify. First, we must maintain and strengthen the Closed Claims Project, which serves as our core resource for studying and improving professional liability in anesthesiology. Second, we need to channel creative efforts into developing methods that will give us a more timely view of changing trends in liability. Third, and perhaps most importantly, we need to sustain our commitment to the basic philosophy that the prevention of injury is the best strategy for management of professional liability.

References:

1. Tinker JH, Dull DL, Caplan RA, et al. Role of monitoring devices in prevention of anesthetic mishaps: A closed claims analysis. *Anesthesiology.* 1989; 71:541-546.

2. Caplan RA, Posner KL, Ward RJ, et al. Adverse respiratory events in anesthesia: A closed claims analysis. *Anesthesiology.* 1990; 72:828-833.

3. American Society of Anesthesiologists Task Force on Management of the Difficult Airway. Practice guidelines for management of the difficult airway. *Anesthesiology.* 1993; 78:597-602.

A list of peer-reviewed publications from the ASA Closed Claims Project is available upon request from the author.

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