Citation

Twersky R, Posner KL, Domino KB: Liability in Office-Based Anesthesia: Closed Claims Analysis. Anesthesiology, A2078, 2013.

Abstract

Introduction: Office-based surgery (OBS) accounted for 10 million elective procedures performed in the United States in 2005, doubled from 1995.[1] OBS is estimated to represent 17-24% of all elective ambulatory surgery.[2] Since 1996, states have considered regulations to address patient safety problems in OBS. However there are still many states lacking any type of oversight of OBS and regulations vary significantly from state to state.

The ASA Closed Claims Project first reported on malpractice claims against anesthesiologists for adverse events in OBS compared to the ambulatory setting in 2001.[3] Most of these 14 OBS claims occurred prior to 1996; 64% resulted in death, and anesthesia care was substandard in 50%. This updated report focuses only on claims after 1996, with the initiation of state regulations.

Methods: After IRB approval, we identified 780 outpatient anesthesia claims for adverse events that occurred between 1996 and 2011 from a database of 9799 claims. Claims associated with chronic pain management were excluded. Claims arising from office settings (OBA, n=64) were compared to other outpatient claims (n=716) with chi square, Fisher's exact test, and Mann-Whitney U test. Severity of injury was categorized as temporary or non-disabling (0-5), permanent and disabling (6-8), or death (9) using the insurance industry 0-9 scale. Payment amounts were adjusted to 2012 dollars using the Consumer Price Index.

Results: Patients in OBA claims were similar to other outpatients: female (65%), middle-age (46 + 18 yrs), and generally healthy (79% ASA 1-2) having elective procedures. OBA claims were more likely to involve plastic surgery procedures (45%) than other outpatient claims (18%, $p<0.0001$). Eye surgery was common in both groups (16% OBA vs. 10% other outpatient). Most OBA claims involved respiratory or equipment adverse events. The single most common adverse event leading to injury in OBA claims was inadequate ventilation or oxygenation (17% vs. 6% other outpatient, $p=0.003$). Cautery fires occurred in 9% of OBA claims (same as other outpatient). Outcomes did not differ between groups, with death in 27% and permanent disabling injury in 17% of OBA claims (Fig). Care was more commonly substandard in OBA claims (52%) compared to other outpatient claims (37%, $p=0.022$), and OBA claims were more likely to result in payment (72%) than other outpatient (56%, $p=0.014$, Fig). When payments were made, they were similar between OBA (median $135,800) and other outpatient claims ($211,500).

Conclusions: Patients in office-based anesthesia malpractice claims were similar to other outpatients but more likely to have plastic surgery procedures. OBA claims exhibited substandard anesthesia care and most resulted in payment. Death was less common in recent OBA claims compared to the earlier Closed Claims report, but substandard care remained

unchanged. Continuing focus on improvements in office-based procedure safety and regulatory oversight for office-based surgery has potential to improve anesthesia patient safety and liability in office-based practice settings.

References:

1. AHA Trendwatch Chartbook 2005.
http://www.aha.org/research/reports/tw/chartbook/2005chartbook.shtml

2. AHA TrendWatch ChartBook 2009.
http://www.aha.org/aha/trendwatch/chartbook/2009/chart2-9.pdf

3. Domino KB. ASA Newsletter 2001; 65(6): 9-11

Figure 1