

Citation

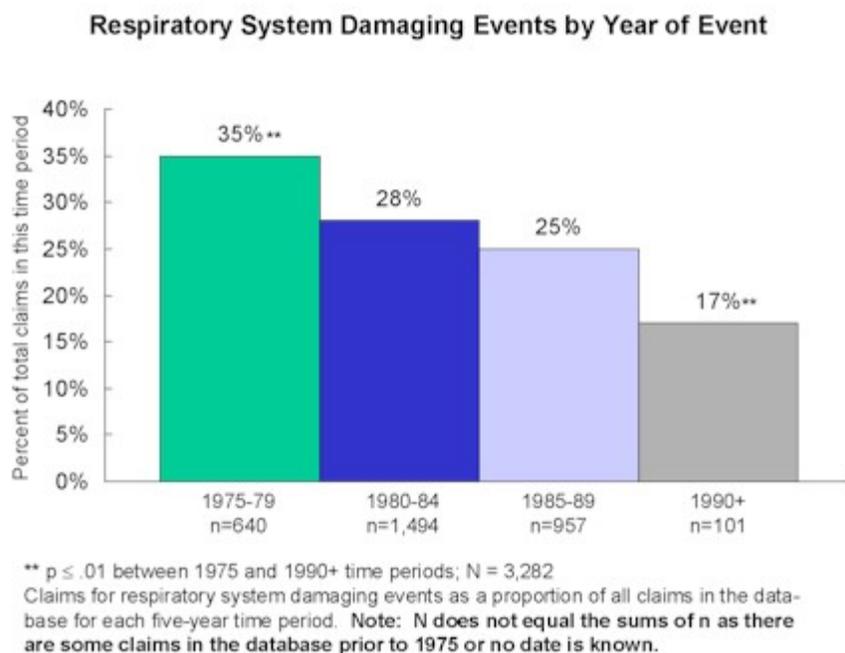
Cheney FW: Committee on Professional Liability - overview. *ASA Newsletter* 58(6):7-10, 1994.

Full Text

The ASA Closed Claims Project, which is the major activity of the Committee on Professional Liability, continues to expand with the addition of a number of cooperating insurance companies. In the past year, closed claims from six more insurance companies have been added to the database. The project now has access to the closed claims of 34 insurance organizations that insure approximately 14,500 practicing anesthesiologists. The data being gathered is undergoing constant review by the Closed Claims Committee at the University of Washington.

Two trends are apparent. The first is that the major category of damaging event or mechanism responsible for the injury leading to the claim has been changing over time. During 1975-79, 35 percent of claims were related to respiratory system damaging events [Figure 1]. These decreased to 28 percent between 1980-84, and in injuries occurring after 1990, only 17 percent of the claims were related to respiratory system damaging events.

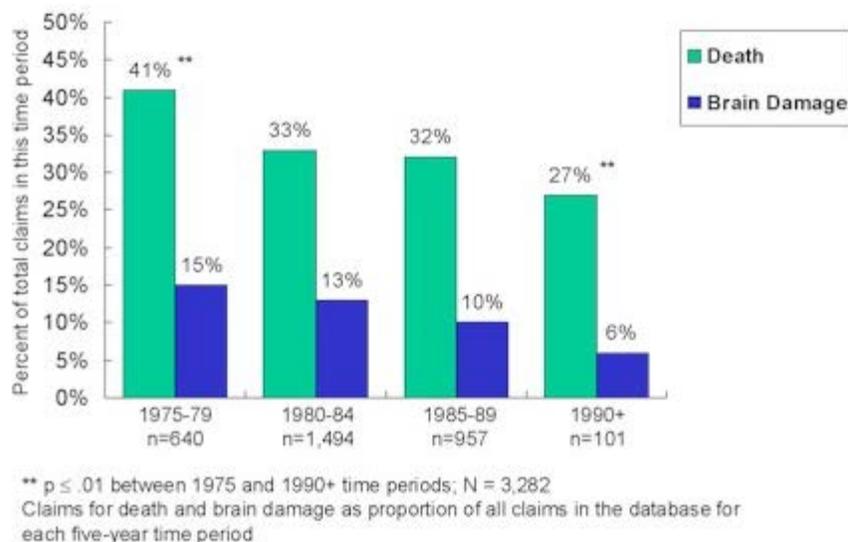
Figure 1



The second trend is that the severity of injury is decreasing as indicated by the incidence of claims for death and brain damage [Figure 2]. Because of the relatively few claims for incidents occurring after 1990, this most recent data must be viewed as tentative. Since it takes approximately five years for claims to close and be added to the database, the profile of claims since 1990 may change as more of these claims are processed.

Figure 2

Claims for Death and Brain Damage by Year of Event



However, the general trend since 1975 is intriguing. Whether this trend will ultimately be borne out when more recent claims become available is impossible to predict. Although it may be tempting to speculate as to the reason for this apparent trend toward fewer claims for respiratory events, death and brain damage, it is not impossible to draw any firm conclusions from this data.

An illustration of some of the new lessons learned from the data of the Project is the report that appeared recently in the journal, *Anesthesiology*¹, which concerns burns that occur during anesthesia. Among 3,000 total claims, there were 54 burns, 28 resulting from materials or devices used to warm patients. The most surprising finding was that 64 percent of these burns were from intravenous bags or plastic bottles warmed in an oven and then applied to the patient's skin. These burns occurred in predominately healthy (ASA 1-2), young (mean 38 17 years) women undergoing routine gynecologic or peripheral orthopedic surgery under general anesthesia.

What is more surprising is that a review of the literature from 1970 to 1993 revealed no reports of burns from warm bags or plastic bottles. There would seem to be little justification for the use of these devices, as they cover only a small area of the skin and would therefore make an insignificant contribution toward prevention of heat loss or maintenance of body heat.

While cutaneous burns are less serious than other complications already reported in the Project (death and brain damage), they do represent a source of morbidity to the patient, a liability risk to the anesthesiologist and a source of financial loss to the insurers.

The Closed Claims Project has had an influence on practice of anesthesiology, as the data has provided justification for certain elements of the ASA Basic Standards for Anesthetic Monitoring and has indicated a need for practice guidelines for management of the difficult airway. A more subtle spin-off from the Project is that in order to carry out its objectives, it was necessary to enlist the assistance of health services professionals. The support from this discipline has been integral to the acceptance of the information into the peer review literature and thus its acceptance by the medical and legal professions.

In this issue of the *NEWSLETTER* ([page 11](#)), Karen L. Posner, Ph.D., a health services analyst and the project manager of the Closed Claims Project since 1986, points out a less favorable influence that health services research has had on the practice of anesthesiology. She points out how flawed health services research and the subsequent erroneous interpretation of the research had led to decisions by the Health Care Financing Administration ([HCFA](#)) as to how anesthesia should be practiced. In a task analysis study for HCFA comparing anesthesiologists and nurse anesthetists,

Rosenbach and Cromwell concluded that nurse anesthetists and anesthesiologists performed the same tasks; and accordingly, nurse anesthetists were a more cost-effective way to provide anesthesia.

This study, with conclusions not supported by the data, continues to be utilized by nurse anesthetists in their efforts to obtain state legislation granting independent practice privileges. This emphasizes the need to scientifically sound health services research in the area of quality of care by provider type. Unfortunately, the only valid comparison is that of anesthesiologists and unsupervised nurse anesthetists; a scientifically valid study would be nearly impossible to achieve, because, in most instances, nurse anesthetists are supervised by anesthesiologists.

The practice of medicine in general and the practice of anesthesiology in particular will be impacted heavily by research relating to costs, outcomes and benefits. It may well be that in the next decade, health services research will have a greater impact on the practice of anesthesiology than basic sciences research.

Also in this issue of the *NEWSLETTER* (page 15), Herbert A. Ferrari, MD, Ph.D., JD, discusses alternatives to the resolution of malpractice lawsuits outside the courtroom. There is no question that arbitration or mediation will reduce the legal costs of settling a claim. However, it is not clear that these methods will alter the incidence and amount of payment to the plaintiff. In my experience and that of many defense attorneys, decisions made by arbitrators or arbitration panels can be capricious and not necessarily consistent with medical reality.

It is true that arbitrators may not award the "blockbuster" amounts that juries may award for a given case. In the aggregate, however, the alternative dispute resolution techniques may represent a way to reducing the transactional costs of settling malpractice claims. This approach would increase the relative amount of total professional liability premium dollars actually received by injured parties. The legal system does not lend itself to prospective studies of costs; therefore, the real impact of alternative disputes resolution on the total cost of professional liability may not be known for many years.

Finally, Gerald F. Tuohy, MD. (page 18), using the knowledge gained from the open claims files of a private professional liability insurance carrier, points out some new areas of liability for the anesthesiologist. It seems that as anesthesiologists' professional activities take them out of the operating room, the lawyers are not far behind. Risk management procedures for the nonoperating room practice of anesthesiologists should be as rigorous as those for the operating room.

References

1. Cheney FW, Posner KL, Caplan RA, Gild WM. Burns from warming devices in anesthesia. A closed claims analysis. *Anesthesiology*. 1994; 80: 806-810. [[Abstract](#)] Order this article from: [ASA Closed Claims Project](#).
2. Rosenbach JL, Cromwell J. A profile of anesthesia practice patterns. *Health Aff (Millwood)* 1988; 7: 118-131.

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