



the Reporter

TEXAS MEDICAL LIABILITY TRUST
Anesthesiology 2008

Failure to manage a high-risk patient Anesthesiology closed claim study

By Marsha Freeman,
Risk Management Representative

Presentation

The patient was a 37-year-old woman with a history of severe sickle cell anemia. Her frequent sickle cell crises resulted in multiple organ dysfunction, including the liver, kidneys, and brain. Poor IV access led to insertion of central lines and port-a-caths. She suffered from edema of the head and neck secondary to superior vena cava syndrome. The patient also had sleep apnea, hypertrophic tonsillitis, and a history of congenital deafness. She used sign language to communicate.

The patient's primary care physician documented that she had multiple episodes of respiratory distress and hypertrophic tonsillitis. It was recommended that the patient have a tonsillectomy to prevent upper-airway obstruction and the edema of her head and neck.

Physician action

The patient arrived at the hospital at 7:30 a.m. for a tonsillectomy and removal of her non-functioning port-a-cath. With the assistance of the nursing staff and her father, the consent, the medical history, and the "anesthesia patient evaluation" forms were completed at 8:10 a.m. There were no time notations as to when the patient was visited or when the forms were reviewed by the anesthesiologist, the defendant in this case. An anesthesia form signed by the defendant indicated that the pre-anesthesia form was reviewed, and that the pa-

tient was identified, interviewed, and examined. The anesthesiologist gave the patient an American Society of Anesthesiology (ASA) score of 3.

The patient was taken to the operating room at 9 a.m., and the surgery began at 9:18 a.m. The anesthesia record showed that anesthesia was started at 9 a.m. and ended at 11 a.m. Anesthetic agents included midazolam 2 mg at 9 a.m.; propofol 100 mg given at 9 a.m.; succinylcholine 100 mg given at 9:15 a.m. and again at 9:45 a.m.; and fentanyl 50 mg given at 9 a.m. and 9:45 a.m. Sinus rhythm was recorded at 10:15 a.m. and then no rhythm was recorded. The heart rate remained in the 80s until 10 a.m., but then dropped to the 70s. Blood pressure was maintained at 110/50-60 until 10:15 a.m., but then dropped to 70/30. The patient was extubated (time not recorded) and transferred to the PACU.

A nurse and the anesthesiologist noted that the patient became apneic at 10:25 a.m. A code was started and the patient was bagged and reintubated by the anesthesiologist at 10:28 a.m. Chest compressions were started at 10:30 a.m. The patient was successfully resuscitated and the code was stopped at 10:45 a.m.; however, the patient developed severe hypertension and remained comatose. At 10:50 a.m., arterial blood gases were pH at 7.047; pCO₂ at 104.5; and pO₂ at 145.7.

The patient was admitted to the ICU at 11:45 a.m. The general consensus among her physicians was that she suffered an anoxic brain injury. She remained comatose and died three weeks later.

A review of the records in this case revealed a time discrepancy during the recovery period. The nurse's notes from the recovery room begin at 10:25 a.m. The print out of the rhythm strips and the blood pressures that are included with the postoperative nurses' notes also occur at 10:25 a.m. This is in conflict with the times recorded on the anesthesia record that place the end of the procedure at 11 a.m. The recovery room nurse documented at 10:25 a.m. "patient in room with anesthesia doctor and operating room nurse. O₂ sat not obtainable. Sinus bradycardia rate 40-20 bpm. Oral airway inserted by doctor Ambu bag applied."

This closed claim study is based on an actual malpractice claim from TMLT. The case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

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On the anesthesia patient evaluation sheet, the anesthesiologist wrote “uneventful anesthesia and recovery. Bigeminy. PS-patient had to be reintubated and ventilated until she was able to breath on her own, post-resuscitation.”

Allegations

A lawsuit was filed against the anesthesiologist and his professional association. The allegations included negligence and failure to perform adequate preoperative evaluation; failure to maintain peripheral IV access; failure to adequately ventilate; failure to monitor changes; failure to timely respond to changes; and failure to correct hypoxia and acidosis.

Legal implications

The major clinical features of sickle cell anemia are chronic hemolytic anemia, recurrent pain in the extremities, abdomen, and back, and a predisposition to thrombosis. Red blood cells from patients with sickle cell disease assume a sickle-like shape upon deoxygenation.

The plaintiff’s anesthesiology expert stated that the defendant breached the standard of care in a number of ways. According to this expert, the defendant should have known that a patient with sickle cell anemia, sleep apnea, and limited peripheral access would require very close observation, and present venous access and airway management problems. The defendant failed to plan for these problems. He also stated that the defendant extubated the patient before she was completely awake and before she could protect and maintain her airway. Further, the patient was clinically unstable during transport to the PACU, and the defendant failed to recognize her symptoms of inadequate ventilation after extubation. The defendant should have immediately reintubated the patient, and this would have avoided her subsequent pulmonary arrest and her severe anoxic brain injury.

The plaintiff’s anesthesiology expert was also critical of the defendant’s documentation. He stated, “A sloppy, poorly documented anesthesia record connotes a sloppy, poorly planned and managed anesthesia!”

An anesthesiologist who reviewed this case for the defense stated that the defendant was not familiar with the complexity of the patient’s condition and was “caught off

guard.” No true preoperative consultation was completed in the records, and the usual anesthetic options were not evaluated for the patient or documented. He was also critical that the defendant used 40% oxygen mixture and only 1000 cc of fluid hydration, no temperature monitoring, and seemed to give little consideration to the problems related to her superior vena cava syndrome. The patient ended up in a sickle cell crisis with hypotension and hypoxemia.

Other anesthesiologists who reviewed this case for the defense were critical of the defendant’s lack of documentation, decision to extubate the patient in the OR, and the fact that he gave the patient an ASA score of 3.

Disposition

Due to the lack of expert support and documentation issues, this case was settled on behalf of the anesthesiologist.

Risk management considerations

According to one anesthesiologist who reviewed this case, when providing anesthesia for a patient with sickle cell anemia, the challenge is to keep that patient from going into crisis. “One has to consider maintaining hydration, normal thermia, good blood flow, avoidance of tourniquets, positioning, and especially oxygenation . . .”

The physician’s most powerful tool for communication is the patient medical record. In reviewing this case, the experts agreed that the lack of documentation by the anesthesiologist contributed to the difficulty in defending the case.

This case also highlights the need for a physician to thoroughly document a patient history and his or her own thoughts and actions. It is vital that physicians be aware of the symptoms and patterns that a patient has been experiencing—information often best gathered via a complete medical history and a thorough exam.

In evaluating this case for the defense, consultant anesthesiologists questioned the defendant’s designation of an ASA score of 3 for this patient. There was also concern about the defendant’s ability to assess and respond to the inherent problems of providing anesthesia for a patient with sickle cell anemia.

Marsha Freeman can be reached at marsha-freeman@tmlt.org.

In case you missed it

ASA issues practice advisory on preventing, managing surgical fires

The American Society of Anesthesiologists released a practice advisory in May 2008 on the prevention and management of operating room (OR) fires.

According to the advisory, though the incidence of OR fires is difficult to determine, “Some estimates suggest that between 50 and 200 OR fires occur in the United States every year, with as many as 20% of reported fires resulting in serious injury or death.”¹

The advisory states that the fires occur when oxygen builds up under surgical drapes during the use of electrocautery or electrosurgical devices and lasers. To minimize the risk of OR fires:

“• Surgical drapes should be configured to minimize the accumulation of oxidizers (oxygen and nitrous oxide) under the drapes and from flowing into the surgical site.

- Flammable skin prepping solutions should be dry before draping.
- Gauze and sponges should be moistened before use in proximity to an ignition source.”

The practice advisory is available at <http://www.asahq.org/publicationsAndServices/practiceparam.htm>.

Source

American Society of Anesthesiologists Task Force on Operating Room Fires. Practice advisory for the prevention and management of operating room fires. *Anesthesiology*. 2008; 108(5):786-801.

TMB enforces new rules for medical record documentation

by Jane Holeman and Jon Porter

For years, the Texas Medical Board (TMB) rules regarding medical record documentation merely required that physicians maintain “adequate medical records,” defined as “any records documenting or memorializing the history, diagnosis and treatment of any patient.”¹ Recently however, TMB staff determined that this rule was incomplete and failed to convey the importance of the medical record. As a result, the TMB radically rewrote the rules defining the requirements for “adequate” medical records.

What exactly does the TMB require?

The rule governing medical record documentation may be found in either the Texas Administrative Code Section 165.1, or in the Board rules posted on the TMB’s web site.² The Texas Administrative Code is the legal designation for the TMB’s rules. The rule states medical records must be “. . . complete, contemporaneous and legible.”¹ Therefore, documentation must include complete details for each patient encounter, be created close to the time the physician treated the patient, and be legible to the average person.

Contemporaneous

The TMB rule does not specifically define “contemporaneous.” However, by practice, most TMB members emphasize that documentation should be completed immediately after, if not during, the actual patient encounter. If a physician chooses to complete the records at the end of the day instead of after the patient encounter, it appears that he or she would be in compliance, assuming the physician did not see a considerable number of patients that day. However, many TMB members are of the opinion that the records then become too general, and it is likely the physician may forget relevant information.

Legible

Legibility has long been an issue for physicians. The advent of electronic medical records and transcribed records is beginning to have a positive impact. However, for physicians who still handwrite notes, illegibility will likely be viewed by the TMB as a lack of compliance with Board rules. When evaluating standard of care issues, all records are reviewed by at least two TMB consultants. These consultants must be able to read the records.

Use caution when employing templates or preprinted forms that contain “check boxes” to designate systems as normal or abnormal. This includes emergency department records and the forms suggested by Medicaid. These forms are often intended to facilitate documentation by “prompting” the physician to address multiple aspects of the patient encounter. However, often the space for handwritten entries is limited, resulting in illegible notes. When using such forms, write legibly and use an additional page to fully describe findings, if necessary.

Complete

The Board requires that each patient encounter must be documented and include the following:

- a. reason for the encounter and relevant history, physical exam findings, and prior diagnostic test results;
- b. an assessment, clinical impression, or diagnosis;
- c. plan for care, including discharge plan; and
- d. the date and legible identity of the observer.¹

There is an expectation that an appreciable connection be made between each of the above four requirements, and that the connection is explored and documented. Therefore, physicians need to demonstrate how they got from the objective and subjective findings to the diagnosis and treatment.

The rule also requires that “past and present diagnoses should be accessible to the treating and/or consulting physician.”² This means that records should be readily available to physicians treating the patient.

Furthermore, the rationale for (if not apparent) and the results of diagnostic testing and other ancillary services should be included in the medical record.¹ This may even include an explanation of the results and how they affect the treatment of the patient.

The rule also requires that the patient’s progress be documented, including response to treatment, change in diagnosis, and the patient’s noncompliance.¹ Defending a standard of care case by alleging the patient was noncompliant may be disregarded if there is a lack of documentation in the record supporting that stance.

Finally, the TMB has traditionally required that physicians document patient follow-up instructions in the medical record. Again, it is recommended that a comment be included regarding how the follow-up instructions were provided to the patient.

Informed consent

The new rules also require documentation of informed consent. Documentation needs to demonstrate that the physician provided the patient (and/or the patient’s family) with education on the diagnosis and treatment, as well as the risks of any treatment. Board members have been critical of physicians who did not document that the diagnosis was adequately explained to the patient, including the differential diagnosis and the affect on the method of treatment.

Treatment plans

The TMB rules also require an appropriate written treatment plan for patients.¹ However, the Board fails to define “appropriate.” As the rules are written, include the following in the plan section of a SOAP note:

1. treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
2. any referrals and consultations;
3. patient/family education; and
4. specific instructions for follow up.¹

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TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140
Austin, TX 78716-0140
800-580-8658 or 512-425-5800
E-mail: laura-brockway@tmlt.org
www.tmlt.org

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Marsha Freeman

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In certain situations, the Board members may expect to see a treatment plan containing more information than what is listed in the four requirements. They actually may request a formal “treatment plan.” This is a written course of action given to the patient with both subjective and objective measures to which the physician and patient agree in order to achieve their stated medical goal.

Generally, TMB members expect a formal treatment plan for patients who have complex or chronic medical conditions. A treatment plan is a requirement when treating patients for issues of chronic pain.³ The treatment of chronic pain has very specific rules and requirements that are not covered in this article. Physicians who provide treatment for chronic pain, should closely review the TMB rules on that subject and contact people with expertise on this rule, such as TMB staff, attorneys specializing in representing physicians before the TMB, or physicians specializing in pain management.

Referrals and consultations

If the physician determines that a referral or consultation is necessary, the rules require that it be documented in the medical record. A copy of the referral or consulting physician’s report should be placed in the medical record. To facilitate patient safety and continuity of care, it is recommended that the referring physician provide a copy of the patient’s medical record or a summary of the patient’s care to the consultant.

Physicians being investigated by the TMB are often unable to demonstrate that they have reviewed the records of prior treating physicians. The TMB rule states that records received from other health care professionals involved in the care of the patient shall be maintained as part of the

patient’s medical records.¹ This means that physicians are required to maintain not only the records they create, but also those they have received from other physicians.

Patient education

There have been instances during informal settlement conferences where a physician has written nothing more than “patient education” in the medical record. In those situations, the Board has emphatically told the physician that the documentation was inadequate. TMB members require that the documentation provide some indication of what was discussed and how the patient was educated.

Conclusion

The rules for medical records are complex and can cause confusion. Carelessness and lack of knowledge of TMB rules have resulted in TMB sanctions for many physicians. Taking time to create and maintain appropriate medical records can help physicians provide better patient care and avoid TMB complaints.

Sources

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Jane Holeman can be reached at jane-holeman@tmlt.org. Jon Porter can be reached at jon.porter@sbcglobal.net.

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