Overview

The aim of Anaesthesia Update is to provide MDA National anaesthetist Members with a “snapshot” of the key medico-legal issues in anaesthetic practice today. Anaesthesia Update is designed to assist in minimising your medico-legal risk with a focus on perennial and emerging medico-legal risks.

This edition discusses:
• medico-legal risks in anaesthetic practice
• what our data shows as the main causes of anaesthetic claims
• increasing use of opioids in the community.

Please contact our Medico-legal Advisory Service about any specific cases or concerns on 1800 011 255 or advice@mdanational.com.au

We welcome your feedback on any specific issues you’d like covered in future editions by emailing us at specialtyupdates@mdanational.com.au

Times Have Changed

What is the most potent current medico-legal threat to anaesthetists?

Guest writer – Dr Andrew Miller

In my opinion it’s lack of understanding that your behaviour or clinical practice may not be appropriate to the times. Any real or perceived deficiencies in either are now more likely than ever to be acted upon by a hospital, medical board or both.

Many of these developments ran in parallel but all seek to reduce reliance on individuals doing the right thing all the time, and put in place systems that will reduce or compensate for human error.

The traditional environment where self-sufficient specialists practiced to their own high or variable standard has been replaced by dependency on structured approaches to quality, safety and management of patients. “Doctor knows best” is dead and audit, accountability and transparency are here to stay. Room for personal preference and quirks has been reduced and in some areas eliminated. These changes pose threats to any anaesthetists and surgeons who do not understand that their cooperation and investment in this new culture is not optional. Perhaps the risk is greatest in smaller more isolated locations where there is little turnover of medical staff and therefore pollination of ideas and questioning of the status quo.

Continuing professional development (CPD) and professionalism

CPD is now mandated by the Medical Board of Australia and audit of CPD is increasing. Recertification is the next possible frontier. Our personal views on professionalism and appropriate behaviour have been augmented and superseded by the adoption of the Medical Board of Australia’s Good Medical Practice: A Code of Conduct for Doctors in Australia¹ (the Code), as well as guidelines on sexual misconduct and mandatory reporting. The Code contains quite prescriptive requirements for anaesthetists and lack of familiarity with the Code is considered unprofessional by the Medical Board.

At the same time there have been improvements in monitoring (e.g. BIS) and procedural techniques (e.g. ultrasound for line and block placement). The advent of video laryngoscopy has the potential to reduce airway incidents and dental trauma, and post-operative pain relief is being augmented by new agents and team approaches. We need to be fluent in these developments.
Best practice

Intersecting with these changes have been quite independent advances in human resource best practice in the areas of bullying, harassment, workplace behaviours and teamwork. Hospitals are increasingly monitoring customer feedback metrics and drilling down into the customer satisfaction data to detect problems with individual practitioners.

Evidence of the risk to anaesthetists comes in the form of rising complaints and investigations by hospitals and complaints commissions. These investigations can be very confronting and indeed career limiting. They are not confined by any means to clinical skills and often have a behavioural component.

None of this of course is reason to despair about the future of anaesthesia or medicine as a profession. There were those who retired early because of the introduction of the GST, which in retrospect seems overly pessimistic. As long as we understand the environment and are willing to adapt, the resulting improvements in patient safety and outcomes will be satisfying enough to make up for the irritation that change inevitably provokes in busy professionals. In order to ensure that compliance does not become a bureaucratic exercise we must remain engaged professionally and politically to continue to fight for common sense. Being part of a professional community also provides protection from processes that can have a brutal face toward an individual.

All workplaces now face the same issues. It may seem draconian and boring, but any human resources manager can refer to a litany of examples where both senior and junior professionals have come unstuck with behaviour that used to be tolerated, but is no longer acceptable.

We are all either employees or accredited under conditions to practice. These arrangements give the hospitals extensive control over our behaviour and any complaint made about us. Employers are also bound to report us to the medical boards if they form a view our practice has “significantly departed from accepted professional standards” putting “the public at risk of harm”.

Practical Tips

- Cooperate with policies and procedures set down by your institutions and the Medical Board of Australia’s Code of Conduct:
  - e.g. time-outs, manual handling processes, hand hygiene, antibiotic guidelines, narcotic register and handling requirements.
- Make a big effort to be current in clinical skills:
  - stay up-to-date with widely available resources
  - stay connected via professional associations.
- Be circumspect in your personal communication and behaviour, as violating simple modern workplace rules can result in protracted administrative inquiries:
  - avoid swearing and any sexual content in conversation or jokes
  - avoid making comment on others’ appearance, personality or lifestyle - staff or patients
  - do not ask personal questions of other staff
  - be aware of what constitutes bullying and harassment - in yourself and colleagues.
- Be sophisticated in understanding the risks of internet and mobile phone use:
  - never “Reply All” on an email, unless completely necessary and innocuous
  - remember these communications last forever and can be misconstrued
  - do not use inappropriately, including by spending too much time online or on the phone while working.
- Utilise institutional complaints mechanisms rather than entering into a dispute head on:
  - instead of raising your voice or creating a scene it is preferable (and usually more effective) to submit an incident report of the facts.
- If you are subject to a formal complaint do not respond or attempt to solve it without advice:
  - contact MDA National
  - remain silent until receiving advice and do not send emails to colleagues
  - remember you are entitled to natural justice – a fair process.

About half of mandatory reports to the Australian Health Practitioner Regulation Agency (AHPRA) are from hospitals and other employers.

Equipped with an understanding of these issues anaesthetists can relax and concentrate on maintaining and updating their clinical skills and CPD. The future is not bleak by any means, but the risks are great if we ignore them. Times have changed, as they do.

1 Good Medical Practice: A Code of Conduct for Doctors in Australia. Available at: www.medicalboard.gov.au
Oxycodone in the Community

Patients are increasingly being sent home post-surgery while still requiring strong analgesia. This has the advantage of making more efficient use of hospitals and reducing exposure to nosocomial pathogens.

Anaesthetists and surgeons are thus faced with logistic and pharmacological challenges in providing acute post-operative pain control in the early discharge setting. Many of us now need to prescribe opiates for home use, and provide repeats direct to pharmacies for patients who have been discharged to remote locations. Australia is now ranked third in the world for oxycodone prescription.

The use of opioids at home has always brought with it some risk, but with the increased use of oxycodone in the community the incidence of serious complications has risen. In the decade ending 2009 oxycodone supply increased nine fold, while there was a twenty fold increase in deaths in Victoria related to oxycodone use. Most of these were ruled unintentional. There is evidence of an illicit trade in oxycodone tablets in Australia.

What responsibility does the prescribing anaesthetist have in this context?

If sending a patient home with this drug, it would be prudent to provide information to explain the potency, the interactions, and the need to avoid overdosage. In particular the use of oxycodone with alcohol, benzodiazepines and illicit drugs should be highlighted as dangerous. We cannot force patients to follow our instructions but we should at least offer the advice where the risk is obvious.

What alternatives are there?

The apparent better community safety profile of codeine may be due to its lower efficacy. There is a significant group who have allergy or prior adverse reaction sufficient to make prescription relatively contraindicated. Morphine in pure form is unlikely to be safer or less addictive than oxycodone, and the abuse potential is high. Dextropropoxyphene has been withdrawn from the market. Tramadol is less efficacious and has a relatively high incidence of side effects. Buprenorphine patches are a helpful addition and as a partial agonist are safer.

Diversion for intravenous abuse is not a problem with the patches. Pregabalin is useful in some types of surgery but can be expensive. Paracetamol is a good foundation drug but insufficient on its own in many post-operative scenarios. Non-steroidal anti-inflammatories can be likewise a useful addition but have a proportion of adverse effects.

How could the system be improved?

The expansion of “hospital in the home” initiatives have led to extensive nursing being provided in the community. Consideration could be given to extending an acute pain service beyond the hospitals to improve provision and safety of analgesia. Dedicated contact or chat lines could also provide and centralise advice.

Pharmacy level controls on prescriptions have been helpful but need to be improved to be "real time", in order to reduce inappropriate prescription, abuse and diversion of the opioids.

The problem of disposal of excess medication has not been satisfactorily addressed in many jurisdictions, such that many patients end up with a store of opioids that are no longer required. Such a stockpile can present a risk in future if used to treat other problems or people.

For anaesthetists the production of standardised information for patients that explains the risks and appropriate usage of these drugs would be helpful.


Anaesthetic Practice Checklist

The following checklist aims to assist you to recognise areas of anaesthesia practice that can be known sources of adverse patient outcomes and medico-legal risk. This list does not claim to be exhaustive or universally applicable but it is designed to generate discussion and help you to create your own practice checklist.

Patient consultation and communication

☐ An appropriate pre-anesthesia assessment is performed on my patients.
☐ I talk to my patients about any past history of anaesthesia and if they have particular concerns.
☐ I discuss options for analgesia and anaesthesia/sedation with my patients.
☐ I examine my patients pre-anesthesia, including teeth and airway.

☐ I discuss expectations held by a patient regarding treatment outcomes and resolve any unrealistic goals.
☐ I know whether a patient has understood the information I have provided to them regarding the appropriate management of anaesthesia/sedation and post-operative pain for their upcoming procedure.
☐ I am available to patients who have questions or concerns about their anaesthesia.
Consent and disclosure
- My patients’ priorities and specific needs are established.
- I ensure my patients understand what will be happening to them and the risks of anaesthesia.
- I find out which risks are important or “material” to my patients.
- I can produce written evidence of consent discussions with my patients.
- My patients are informed of my billing practices and financial consent is obtained if relevant.

Anaesthesia records
- I keep records in a manner that other members of the health care team can understand the patients’ care.
- Consultations and anaesthetic management are documented contemporaneously.
- I document all relevant history and examination findings.
- I make a note of condition of dentition, particularly loose, chipped or broken teeth, bridged teeth or dental implants.
- I document any specific advice given to patients.
- I record details of any complications that may have occurred, and action taken.
- I ensure that when I use abbreviations, they are unambiguous and universally accepted.

Intra-operative care
- I check and ensure adequacy of equipment before commencing a procedure.
- I familiarise myself with the team and theatre.
- I familiarise myself with facility procedures and protocols.
- I ensure safe patient positioning.
- I am personally responsible for drawing up and administering anaesthetic agents and medications.
- I am aware of my own and the team’s level of fatigue, stress and attentiveness.
- I support my facility’s protocol for “time out”.

Post-operative care
- Recovery and ward staff understand when they need to contact me.
- I am confident that recovery and ward staff have appropriate experience to manage post-operative care.
- My hospital/facility has adequately equipped and staffed facilities to ensure safe care of patients.
- I am available to be contacted to review my patients when necessary, and I encourage contact when it is made.

Telephones and messaging
- Phone calls relating to patients are returned in a timely manner.
- I do not over-use my phone in clinical settings.
- Messages from or about patients regarding clinical matters are documented.
- Any clinical advice given to patients via telephone is documented in the patient record at the time of the call or as soon as practicable.

Test result and referral tracking
- I ensure patients whom I have sent for specialist consultation or investigations prior to a procedure have attended.
- I do not proceed with anaesthesia until the results of relevant tests are available.

Privacy and confidentiality
- Patient information is collected, stored and transmitted in accordance with the National Privacy Principles.
- I am aware of the precautions I need to take when using email to exchange patient information.
- Patient information is kept out of view and earshot of other patients or members of the public.
- My electronic data is secured appropriately.

Complaints and adverse events management
- I am familiar with the Medical Board of Australia’s Good Medical Practice: A Code of Conduct for Doctors in Australia.
- I take care of myself to minimise fatigue, stress and inattention.
- I understand and participate in my hospital/facility’s incident reporting and open disclosure processes.
- I offer patients the opportunity to discuss a complaint face-to-face.
- I contact MDA National for advice about complaints and adverse events prior to meeting or responding in writing to a complaint.

MDA National is available to provide individualised advice to assist you develop strategies to address identified areas for improvement and more information on known sources of medico-legal risk.
The Causes of Anaesthetic Claims

Dental damage associated with anaesthesia remains a fact of life for anaesthetists and their patients. Analysis of MDA National’s claims data reveals that 48% of claims against anaesthetists involve dental damage (see Chart 1).

While these claims account for only 3% of the total costs of anaesthetic claims, any steps that can be taken to minimise their frequency is worthwhile.

This article describes the nature and causes of dental damage during anaesthesia and outlines some risk management strategies to reduce the occurrence of these claims.

Case study
An anaesthetist contacted our Medico-legal Advisory Service to report dislodgement of a maxillary central incisor in an elderly patient during a difficult intubation. Pre-operatively the anaesthetist had carefully examined the patient’s mouth and warned him of the possibility of damage to the incisor, which was already loose. Post-operatively, the patient asked our Member who was going to pay for his dental treatment.

Not unreasonably, the anaesthetist was adamant that he was not responsible for the repair of the dental damage that had occurred during a carefully performed anaesthetic. After discussion with MDA National, it was agreed that the anaesthetist would advise the patient that, while he was sorry that the crown had been dislodged, the patient would have to pay the bill for the dental treatment. The anaesthetist subsequently received a letter from the patient requesting payment of his dental fees.

MDA National assisted the anaesthetist in providing a response to the patient, outlining the care he had taken to minimise the possibility of dental damage. Fortunately no formal claim ensued, despite the patient’s initial dissatisfaction with our Member’s approach.

Is dental injury during anaesthesia negligent?
Dental injury during properly conducted anaesthesia is not, by definition, negligent. When determining whether or not a claim involving dental injury should be settled, MDA National will consider the circumstances of the particular case and the preferences of the Member. Assessment of the case includes the Member’s pre-operative evaluation of the patient and whether or not the dental damage occurred as a result of the anaesthetist’s actions. There are cases where the dental damage may not be related to the anaesthetic, especially where there is a delay between the procedure and the occurrence of the damage. Dental damage may occur in recovery e.g. during removal of a laryngeal mask or suctioning by nursing staff.

On occasion, a patient may incorrectly allege that pre-existing dental problems were caused by the anaesthetist e.g. damage to a molar which is virtually unheard of as a consequence of an anaesthetic.

Similarly, situations where a patient has poor dentition and is warned of the risk of dental damage may not involve negligence.

Risk management strategies
The following risk management strategies will minimise the likelihood of your involvement in a claim arising out of anaesthesia related dental damage:

- Ensure recovery staff are aware of the potential hazards of forceful removal of oropharyngeal airways and laryngeal masks when the teeth are clenched.
- When dental damage has occurred, locate the tooth fragment as soon as safely possible and institute immediate emergency management of the dental trauma.
- Explain to the patient how the damage occurred, without self-blame, and describe any efforts that were made to avoid injury.
- Do not introduce the subject of costs or offer to pay for the dental treatment.
- In some circumstances, consider reducing or waiving the anaesthetic fee.

- Check for dental damage after intubation,
- Take care with the technique of intubation
- Record the type of airway management
- Document your pre-operative discussion
- Discuss the possibility of dental damage
- Take a dental history and perform an oral examination before general anaesthesia
- Discuss the possibility of dental damage with patients, especially when there are pre-existing dental problems
- Document your pre-operative discussion and assessment in the medical records
- Significant findings should be noted
- Record the type of airway management and any difficulties encountered. Indicate if no oral instrumentation was employed
- Take care with the technique of intubation and the use of oropharyngeal suction
- Check for dental damage after intubation, extubation and recovery. Document any relevant findings.

Members are encouraged to seek early advice and assistance from our 24 hour Medico-legal Advisory Service on 1800 011 255

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<thead>
<tr>
<th>Percentage</th>
<th>Cause</th>
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<tbody>
<tr>
<td>48%</td>
<td>Anaesthesia – dental issues</td>
</tr>
<tr>
<td>17%</td>
<td>Anaesthesia – CNS/CVS &amp; potential medium/high value matters</td>
</tr>
<tr>
<td>12%</td>
<td>Anaesthesia – nerve &amp; musculo skeletal injuries - direct /pressure/ positioning</td>
</tr>
<tr>
<td>5%</td>
<td>Anaesthesia – inadequate pain relief/awareness</td>
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<tr>
<td>3%</td>
<td>Medication related</td>
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<tr>
<td>3%</td>
<td>Consent issues</td>
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<tr>
<td>1%</td>
<td>Diagnosis</td>
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<td>General duty of care</td>
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<tr>
<td>1%</td>
<td>Treatment</td>
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<tr>
<td>9%</td>
<td>Other</td>
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Chart 1. Causes of claims involving Anaesthetists

An Annual Update for MDA National
ANAEStHETIST MEMBERS
Resources for Anaesthetists

MDA National provides a range of online resources specifically for anaesthetist Members, including:

- Practice Self-assessment Checklist
- Practice Self-assessment Handbook

To access these resources visit www.mdanational.com.au

Snapshot: Defence Update Online

Members can now read Defence Update online for more detailed information and related links on emerging issues, case studies and practical medico-legal resources. Access our online publication at your convenience via your computer, smart phone or tablet today, share articles, save them to file and tell us what you think.

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The information in Anaesthesia Update is intended as a guide only. We recommend you always contact your indemnity provider when you require specific advice in relation to your insurance policy. The case histories used have been prepared by the Claims and Advisory Services team. They are based on actual medical negligence claims or medico-legal referrals; however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.