

# THE SCOPE



## MEDICAL EDITION

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The Top Allegations Keeping Anesthesiologists Awake

Social Media Hygiene for Healthcare Organizations

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## EDITORIAL STAFF

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## EXECUTIVE MESSAGE

Dear Policyholders,

I hope you are all enjoying some wonderful weather after a cold and rainy spring and have been taking advantage of opportunities to gather with family and friends in ways that we may not have been able to over the past two years.

Spring is considered a time of renewal, and, coincidentally, it is also the period that precedes the July 1 medical professional liability insurance renewal date for most New York medical practitioners. This issue of *The Scope* features two articles relating to insurance in New York state. They provide an overview of the Regulation 124 excess insurance program and an examination of the factors that all New York state medical professionals should be considering when purchasing their liability insurance. I hope you find these articles to be of interest and value.

This issue also features the first installment in a series of articles that will examine the medical professional liability issues related to a given specialty. We start off this series with anesthesiology, the practice of which can also have direct liability implications on CRNAs and any surgical specialties that require anesthesiology. We certainly welcome your feedback on this article, and please let us know if there is a particular specialty or combination of specialties that should be examined in a future issue.

As always, I welcome hearing from you on any and all subjects.

Wishing you a happy summer!

All the best,

A handwritten signature in black ink, appearing to read "John". The signature is stylized and written in a cursive-like font.

**John W. Lombardo, MD, FACS**

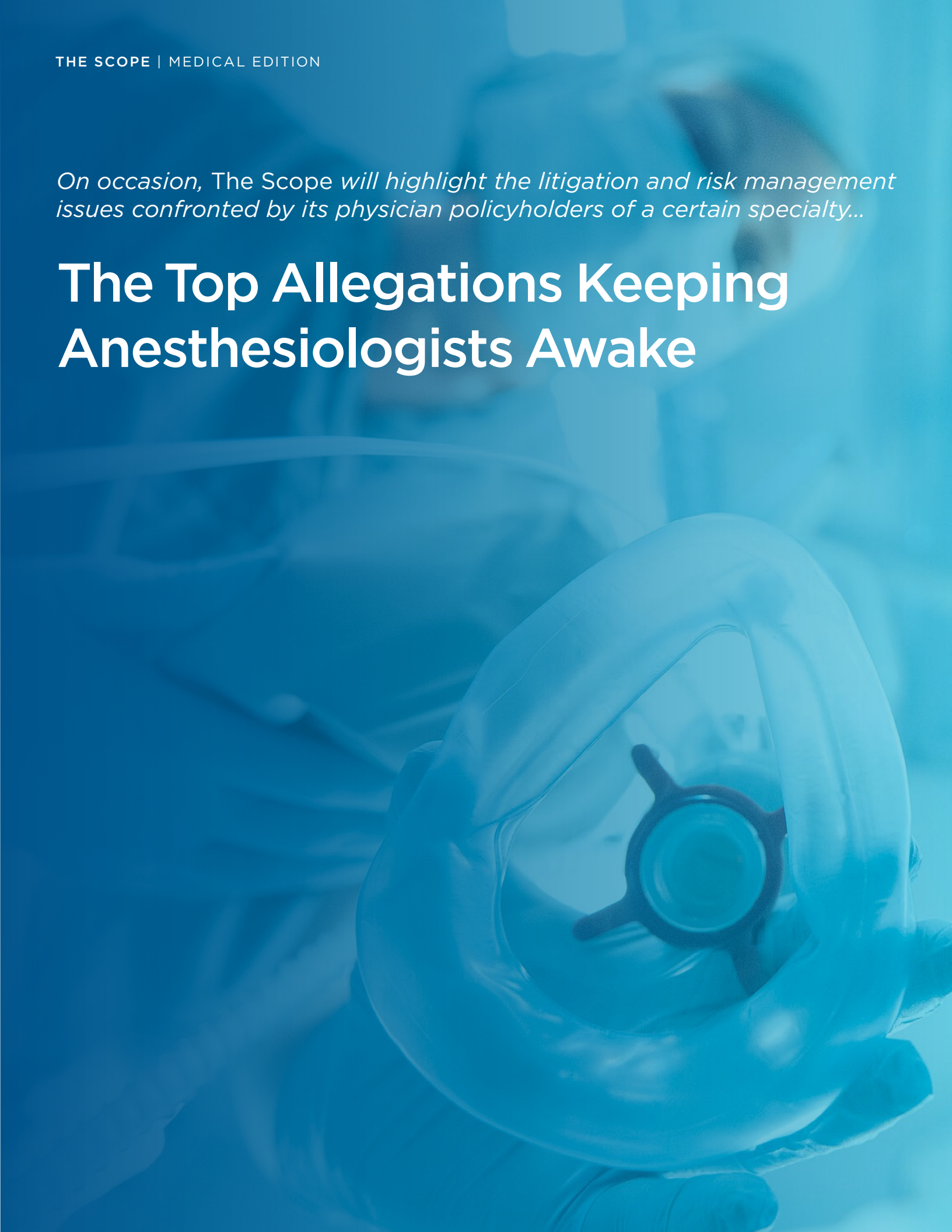
Chief Medical Officer, MLMIC Insurance Company

[jlombardo@mlmic.com](mailto:jlombardo@mlmic.com)



*On occasion, The Scope will highlight the litigation and risk management issues confronted by its physician policyholders of a certain specialty...*

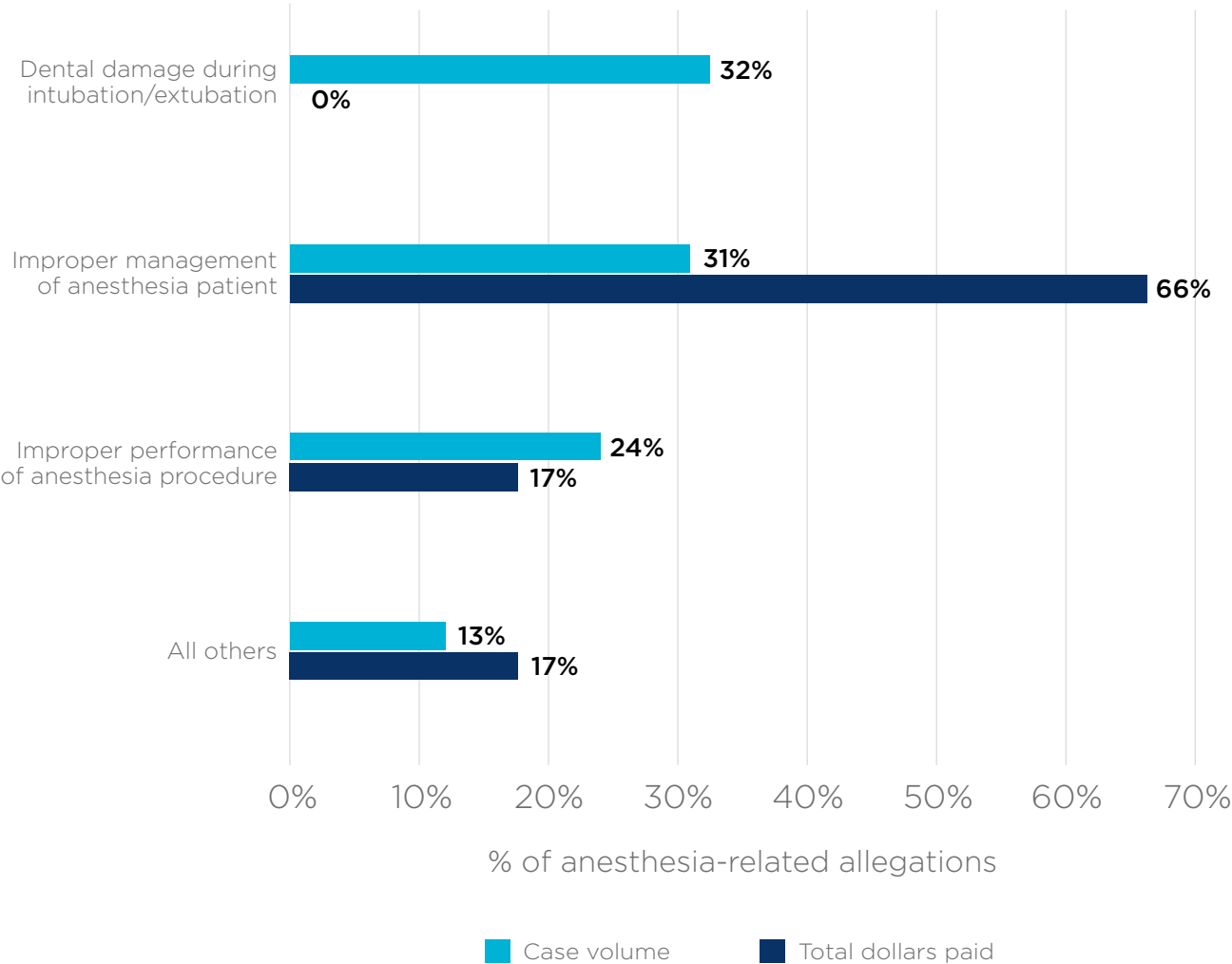
# The Top Allegations Keeping Anesthesiologists Awake



According to a recent joint study<sup>1</sup> by MLMIC Insurance Company and MedPro Group of approximately 2,500 inpatient surgical suite and ambulatory surgery center claims closed between 2015 and 2020, an anesthesiologist was identified as the responsible specialty 88% of the time. The same study showed that Certified Registered Nurse Anesthetists (CRNAs) were involved in approximately 39% of the claims made against an anesthesiologist. This article will focus on what the analytics from that study revealed about the top anesthesia-related allegations, the contributing factors related to those allegations, and the CRNA influence on anesthesia-related allegations.

### Focus on MLMIC Analytics: The Top Anesthesia-Related Allegations

## Anesthesia: Top Claims



Not surprisingly, the study revealed that dental damage during intubation or extubation made up a third of all anesthesia-related allegations. However, allegations involving dental damage accounted for a negligible amount of the total dollars paid. In sharp contrast, while “improper management of the anesthesia patient” also made up about a third of the anesthesia-related allegations, those allegations made up two-thirds of the total dollars paid.

1. Data source: MLMIC + MedPro Group closed cases that opened between 2015 and 2020, inpatient surgical suite or ambulatory surgery center as the location (total cases = approx. 2,500).

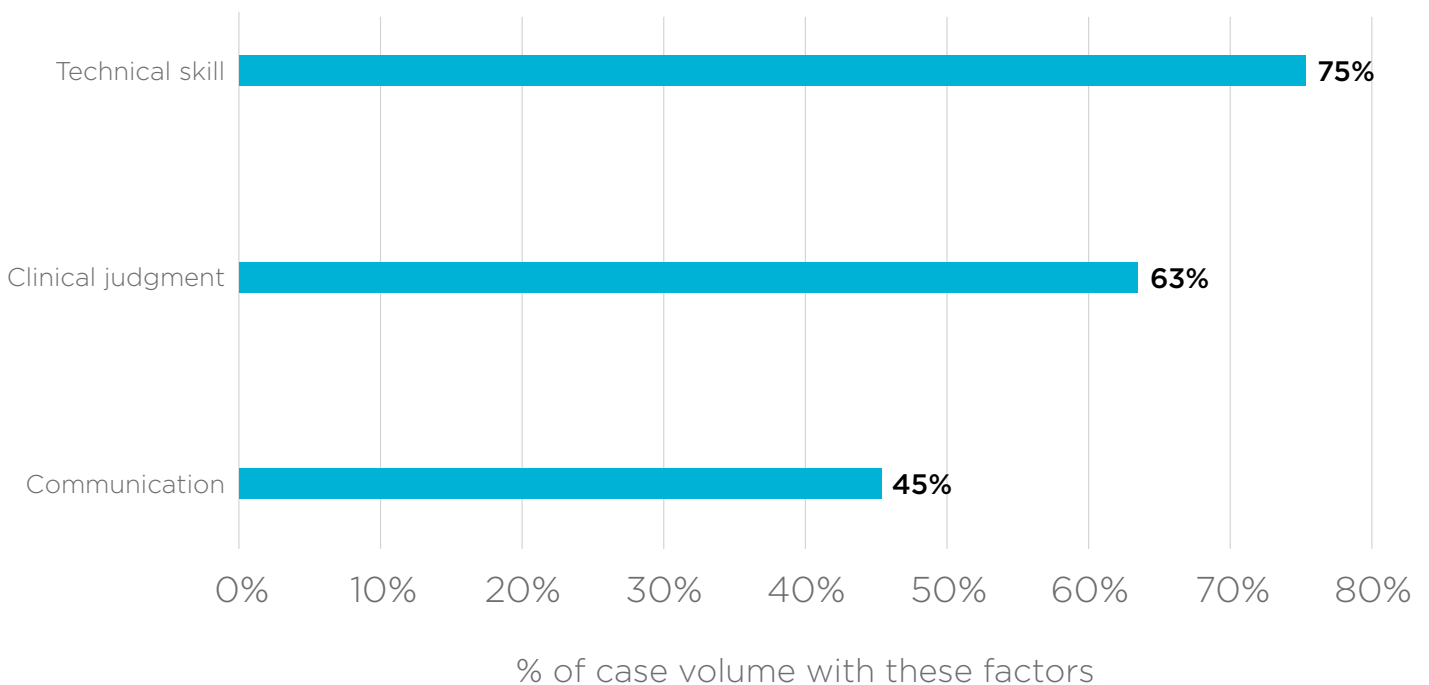
According to the study, “Improper performance of an anesthesia procedure” made up 24% of the anesthesia-related allegations and accounted for 17% of the total dollars paid.

According to the study, “Improper performance of an anesthesia procedure” made up 24% of the anesthesia-related allegations and accounted for 17% of the total dollars paid. The category “All others” consisted of allegations involving an anesthesiologist but were related to medications, obstetrics (delivery), and pain management.

### Focus on MLMIC Analytics: The Top Three Contributing Factors Leading to Anesthesia-Related Allegations

Contributing factors are multilayered issues or failures in the delivery of patient care that contribute to an untoward outcome and/or the initiation of a case, or have a significant impact on case resolution. Contributing factors reflect breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. In analyzing the data, more than one contributing factor can be identified as contributing to an anesthesia-related claim. We will examine the top three contributing factors leading to anesthesia-related claims.

### Top Three Contributing Factors



The top three factors contributing to the anesthesiology claim or suit involved technical skill, clinical judgment, and communication.

### Technical Skill

Technical skill involves procedural skill issues and factors related to the improper use of equipment, medication errors, and retained foreign bodies.

**94% of cases involving a technical skill factor had issues relating to technical performance.**

**Top Technical Skill Contributing Factors:** 94% of cases involving a technical skill factor had issues relating to technical performance. Technical performance encompasses poor procedural technique/competency, the failure to manage a known complication, incorrect body positioning, and using an inappropriate method of administering medication. Medication errors were a factor in 5% of the cases, improperly utilized equipment was a factor in 5% of the cases, and a retained foreign body was a factor in 2% of the cases.

### Clinical Judgement

Clinical judgment, or clinical decision-making, includes factors related to the selection and management of therapy, patient assessment, patient monitoring, any failure/delay in obtaining a consult, the failure to ensure patient safety (e.g., side rails, restraints), the choice of practice setting, the failure to question/follow an order, and practicing beyond the scope of practice.

**Top Clinical Judgment Contributing Factors:** 63% of cases involving clinical judgment as a factor had issues relating to the “selection and management of therapy,” which involves the provider’s judgment concerning the best or most appropriate procedure, the most appropriate location for conducting the procedure, choosing the most appropriate medication, and proper patient selection.

Patient assessment issues were a factor in 60% of the cases. This encompasses the failure to appreciate relevant signs, symptoms, and/or test results, the failure to escalate, inadequate pre-op assessment, and the failure to reconcile changing vital signs.

Patient monitoring was a factor in 43% of the cases. This encompasses the failure to recognize a change in physiological or behavioral status, and any failure or delay in responding to a clinical alarm system.

Other factors identified included the failure or delay in obtaining a consult or referral (5%) and the failure to ensure patient safety (5%).

### Communication

These factors are related to communication among providers, communication between the patient and/or the patient’s family and providers, and providing inadequate informed consent.

**Top Communication Contributing Factors:** 61% of all cases with communication issues were specific to communication between the patient and/or their family and the providers. This involves providers failing to discuss and set patient expectations, issues relating to informed consent (i.e., discussing the treatment risks and benefits, and any alternative options), and patient/family education. A subset of communication factors includes issues with electronic communication such as telemedicine/telehealth, patient portals, and email communication.

**61% of all cases with communication issues were specific to communication between the patient and/or their family and the providers.**

### Additional Contributing Factors: Supervision and CRNAs

Supervision was found to be a contributing factor that occurred in 21% of all anesthesia files reviewed. In addition, of the files reviewed, CRNAs were involved in 39% of the cases and their actions impacted the patient’s outcome.

## Focus on MLMIC Analytics: The Severity of Anesthesia-Related Injuries

The [National Association of Insurance Commissioners \(NAIC\)](#) has a three-tier rating system for injuries: high severity, medium severity, and low severity.

**High severity** is defined as:

- Permanent Significant — deafness, or the loss of a limb, eye, kidney, or lung;
- Permanent Major — paraplegia, blindness, the loss of two limbs, or brain damage; or
- Grave — quadriplegia, severe brain damage, requiring lifelong care, a fatal prognosis, or death.

**Medium severity** is defined as:

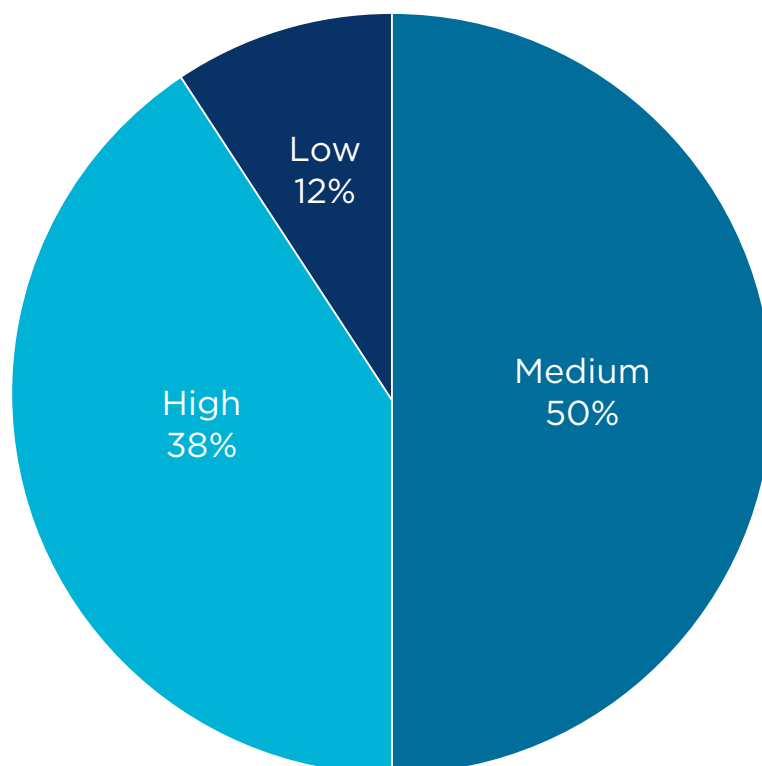
- Temporary Minor — infection or an improperly set fracture;
- Temporary Major — burns or surgical material retained; or
- Permanent Minor — the loss of a finger or damage to an organ.

**Low severity** is defined as:

- Emotional Only — e.g., fright; or
- Temporary Insignificant — lacerations, minor scars, or rash.

The MLMIC MedPro Group study of anesthesia-related injuries in cases between 2015 and 2020 broke down the severity of injuries as follows:

### Breakdown by Severity





For the anesthesia-related injuries reviewed, “**High severity**” included death, the need for neurosurgical intervention after cervical epidural steroid injection caused hematoma, and permanent persistent pain. “**Medium severity**” included postdural puncture headaches and photophobia, allergic reaction to agents used, and aspiration pneumonia. “**Low severity**” included dental damage during intubation or extubation, inadequate anesthesia during C-section resulting in undue pain and emotional injury.

**“Medium severity” included postdural puncture headaches and photophobia, allergic reaction to agents used, and aspiration pneumonia.**

### Supervision of CRNAs and Anesthesiologists’ Liability Risk

A certified registered nurse anesthetist is a licensed registered nurse who has completed additional training in anesthesia in an accredited program and is certified by a national organization to give anesthesia to patients.<sup>2</sup> Despite national certification, CRNAs are registered nurses under New York law.

New York Department of Health Regulations governing the administration of anesthesia within a hospital permit CRNAs to perform a variety of functions under the supervision of an anesthesiologist who is “immediately available”<sup>3</sup> or an operating physician who has agreed to accept responsibility for the CRNA.

It should be noted that a CRNA poses an increased risk of exposure for an anesthesiologist over an operating physician.

- **NYS Department of Health regulations do not require the operating physician to attend to a patient during emergency from anesthesia.**

- **A physician’s liability for injuries resulting from the wrongful administration of an anesthetic is more limited.**
- **The physician does not have the recognized technical expertise of CRNAs in administering anesthesia.**
- **The physician does not have expertise in the use of specific anesthetics to correct the harmful effects of other anesthetics.**
- **An anesthesiologist is required to be “immediately available” when supervising a CRNA, which is generally interpreted as being physically present within the hospital, preferably within the operating suite.**
- **The anesthesiologist must remain physically available for the immediate diagnosis and treatment of emergencies administering anesthesia.**
- **An anesthetist must be present to attend to a patient during emergence from anesthesia.**

CRNAs may perform many functions under the supervision of a physician. These functions include:

- Obtaining consent to anesthesia while under the supervision of an anesthesiologist or operating physician<sup>4</sup>
- Performing diagnostic spinal taps
- Inserting bronchoscopes to observe placement of double lumen endotracheal tubes
- Inserting a “Bougie” device for bariatric procedures
- Placing an endoscope in the esophagus and advancing it while the surgeon directly visualizes the scope, and manipulating the scope from below to ensure that it is in the right place
- Inserting an epidural catheter for pain control in the labor and delivery area of an Article 28 facility

*continued on page 14 ›*

2. 10 NYCRR 700.2 (b)(22): A certified registered nurse anesthetist or registered nurse anesthetist or nurse anesthetist shall mean a registered professional nurse licensed and currently registered with the New York State Education Department who:  
 (i) has satisfactorily completed a prescribed course of study in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Education Programs/ Schools or other accrediting body which the commissioner finds to be substantially equivalent;  
 (ii) has passed the national certifying examination given by the Council on Certification of Nurse Anesthetists or other certifying examination which the commissioner finds to be substantially equivalent; and  
 (iii) is currently certified by the Council on Certification of Nurse Anesthetists or by the Council on Recertification of Nurse Anesthetists or other accrediting body which the commissioner finds to be substantially equivalent.

3. “Immediately available” has been interpreted as being physically present within the hospital and preferably in the operating suite. See 10 NYCRR 405.13 (1)(iv).

4. See the New York State Department of Education memo from May 2006, opining that the CRNA is the appropriate person to obtain consent for anesthesia in this scenario.

Risk Management Tip:

# Social Media Hygiene for Healthcare Organizations

**The Risk:** Healthcare communication continues to become more electronic, and while social media accounts tend toward a more casual communication style, healthcare providers must remain vigilant about the security of their platforms, as well as the message they convey to their patients and potential patients.

Social Media Hygiene is a set of practices and behaviors related to cleaning up and maintaining your digital presence, in terms of both security and the message your social media applications deliver to patients and potential patients.<sup>1</sup> Much in the same way as we wash our hands with soap and water regularly, it is also critical to follow those practices that will keep you and your virtual data well protected, and convey an appropriate message for your organization.

1. <https://www.cloverinfotech.com/blog/cybercrime-is-infectious-digital-hygiene-is-the-vaccine/>

**Recommendations:** Performing proper social media hygiene is a two-step process, the first of which is system hygiene:

**1. Regularly update all electronic devices and applications as recommended**

**2. Use passwords that follow appropriate security protocols:**

- Longer passwords are more secure: eight or more characters is recommended
- Passwords should include different characters: numbers, symbols, and at least one capital letter
- Avoid recycling passwords
- Do not use the same password for all devices/apps/accounts
- Do not allow staff to share passwords

**3. Review file organization stored on your devices:**

- Determine that you have the right information and applications on the right device
- Define those files that are mobile, laptop, and PC-appropriate

**4. Optimize factory settings:**

- Use default settings as appropriate
- Know how to disable, lock, or erase information in the event of device theft

**5. Use multifactor authentication (MFA) for logging into your social media accounts**

**6. When able, employ device encryption**

**7. Lock down who can see your posts/information**

These steps are often cited as the best measures to employ for protection against cyberattacks. However, your cybersecurity must extend beyond your device to include the information that is attached to you and your practice.

Reviewing the information on your social media platforms is the profile hygiene portion and second step of this process:

**1. Analyze your current media profiles to determine if there is anything that:**

- Must be immediately addressed or can wait for revisions
- Is no longer current

**2. Clean up your digital past:**

- Delete old photos and posts that are no longer relevant
- Delete old and/or neglected social media accounts

**3. Ensure that the privacy settings on your platforms remain up to date**

**4. Review your blog and website:**

- Ensure that all information remains relevant and accurate
- Consider whether the message presented about your practice is as you intend
- If links are embedded, test that they are still functional and appropriate to your message.
- Delete any stale/non-functioning links, and if appropriate, replace with current information

Routinely performing social media hygiene can help protect your practice from security breaches, keep your social media sites informative, and improve patient satisfaction.



A photograph of a male doctor in a white lab coat and a woman in a dark blazer sitting at a table. The doctor is pointing at a laptop screen while the woman looks on. There are coffee cups on the table. The image has a blue overlay.

# MLMIC's Physicians and Surgeons Excess Professional Liability Insurance Coverage

An Added Layer of Available Protection



New York State legislation had established the malpractice excess liability program under Section 18 of the Medical Malpractice Reform Act of 1986. Consequently, Excess Professional Liability Coverage emanating from this program is often referred to as “Section 18” coverage. This coverage provides an additional layer of insurance protection, over and above the requisite primary limits of liability of \$1.3 million each person/\$3.9 million total. Offered at no additional cost to those who qualify under State regulation and to whom MLMIC offers such coverage to its primary physician/surgeon insureds, Section 18 coverage is made available to physicians, surgeons, and dentists in New York State who meet certain eligibility requirements. These program eligibility requirements are subject to change over time and are currently as follows for all candidates, who must:

- Maintain a primary affiliation with a New York state general hospital
- Render emergency medical services at the primary affiliated general hospital from time to time
- Maintain primary medical professional liability insurance coverage having limits of \$1,300,000/\$3,900,000 with a carrier authorized to do business in New York
- Complete a qualified risk management course within the two years prior to the excess policy effective date

For those insureds not meeting the requirements above or having an available hospital “slot” (as described below), a direct pay option is available.

It is important to be aware that MLMIC’s Section 18 excess coverage availability varies in that it is offered to eligible insureds in most specialties and territories but not to all. Furthermore, state-funded “free” excess is predicated on each New York State hospital being allotted a specific number of “slots” for physicians, surgeons, and dentists who have met the requirements outlined earlier on. Enrollment in the program is open to new applicants from

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July 1 through December 31 of each year. New applicants who do not have a current Section 18 excess policy in force are placed on a wait list until the respective hospital's additional eligible slots are released by New York State, and the hospital has reviewed and approved such new applicants. Unfortunately, there will not be an available slot for every new applicant as determined by their affiliated hospital. However, as previously stated, a direct pay option is available to those insureds who desire this coverage, albeit at an additional cost to them.

Current policyholders who receive their Section 18 excess coverage standard renewal notice through MLMIC were sent a standard renewal notice, which was mailed on April 29 of this year. The excess renewal communication is sent out to ensure completion and submission of the requisite annual renewal application. This prior communication provided relevant detail of the process, including instructions for recipients to log into their accounts on the MLMIC secure portal to access their excess renewal application. Completed excess applications were due back to the Company by June 1, 2022. In addition, the program's requisite Risk Management course for the upcoming renewal term must be completed by insureds between the dates of July 1, 2020 and June 30, 2022.

In furtherance and benefit of this program to the medical community, the recently enacted New York State Budget for 2022-23 continues the Physician's Excess Medical Malpractice (Section 18) Program with no modifications from prior years. As indicated in our [Albany Report](#) (NUMBER 02 | 2022), the proposed budget had originally called for Section 18 eligible physicians and dentists to pay for their own excess medical malpractice insurance premiums, with subsequent reimbursement made to them by the State over a period of two years. However, Governor Hochul subsequently modified this proposal to provide for payment of these premiums to the respective carriers by the State in two equal installments, spread out over a period of two years. With concern over the financial well-being of program participants, MLMIC worked diligently with MSSNY and our other partner medical societies to advocate for restoring full program funding without any modifications so that no financial burden would be placed on any of its policyholders.



**Robert Pedrazzi** is an Assistant Vice President of Underwriting with MLMIC Insurance Company.

[rpedrazzi@mlmic.com](mailto:rpedrazzi@mlmic.com)

# Considerations Before Purchasing Medical Professional Liability Insurance Coverage in New York

Protect yourself by being fully informed of your professional liability insurance coverage, your policy limits, the coverage maintained by potential codefendants, and the priority of coverage (or other insurance). Assess the New York environment of competing carriers, the benefits of New York State licensure, and the value of insuring with a carrier who for over 45 years has stood by New York physicians in partnership with the Medical Society of the State of New York.

**Eligibility for Free Excess Insurance:** Physicians insuring with carriers not licensed in New York and physicians with shared limits are not eligible for free Section 18 excess coverage, which provides an additional \$1 million per claim and \$3 million aggregate above the standard policy limits.

**New York CME and Risk Management Services** provided to policyholders are important considerations. Does the carrier provide free online continuing medical education (CME) that meets NY Section 18 excess coverage requirements? Are onsite meetings, educational presentations, and risk management services made available at your practice or facility? Are specialty-specific claims analytics that reflect the NY experience presented? Does the carrier have a 24-hour emergency hotline?

**Policy Limits:** Policies issued by excess/surplus insurers include allocated loss adjustment expense (the costs of litigation and defense) within the policy limit. This reduces the policy limit available to pay a medical malpractice judgment or settlement.

**Deductibles:** Excess and surplus policies may contain a deductible, requiring reimbursement by the policyholder. Hospitals or practices should assess the credit risk of getting reimbursement.

**Shared Limits:** If practice groups or hospitals have policies with shared limits (as opposed to separate limits), it is important to know the limits available for each practitioner and whether the aggregate (total shared limit) is sufficient to cover the number of practitioners insured.

**Contracts between practitioners, groups, or hospitals** may require indemnification, coverage limits (shared or separate), priority of coverage, or named or additional insured coverage.

**Hospital bylaws** may require attending physicians to carry certain policy limits as a prerequisite to granting privileges. Bylaws may also require entity coverage for your practice.

**Separate Professional Entity Coverage** provides an additional limit if the practice or employee of the practice is named as a defendant.

**Get the facts.** You may hear about another carrier's "retirement plan" for policyholders. It's not a 401(k) or an IRA. It's not guaranteed. Know the qualifying conditions and the multiple reasons your funds could be forfeited.

Should you have any questions, please feel free to call (800) ASK-MLMIC or visit us online at [MLMIC.com](https://www.mlmic.com).



*The following case studies illustrate two different clinical scenarios involving claims made against anesthesiologists.*

### **Case Study #1 Patient Selection and Management**

The patient was 23-year-old female with a history of morbid obesity and obstructive sleep apnea, which was diagnosed by an ENT. The ENT opted to perform a uvulopalatopharyngoplasty and tonsillectomy in an outpatient surgical center. The anesthesiologist completed a preoperative anesthesia assessment and assigned Class IV modified Mallampati classification since the soft palate was not visible. The patient had good oral opening, but limited extension. The anesthesiologist assigned ASA III, the highest classification allowed for an outpatient surgery setting. The patient signed only part of the anesthesia consent.

The surgery was completed by the ENT and was uneventful. In the postoperative period, the patient's oxygen saturation dropped to between 70–90%. Once she met extubation criteria, she was extubated, but within five minutes of extubation, her oxygen saturation dropped to the 60s with pulmonary froth.

The anesthesiologist used a mask with positive pressure support and her oxygen saturation increased to 85–90%. The patient was given 12mg of Lasix for pulmonary edema and she stabilized. The patient slept for about 45 minutes and her oxygen saturation remained in the 90s.

Since she was doing well on a non-rebreather mask, a transfer to the hospital was planned.

Twenty minutes after the transfer was planned, the patient needed to use the restroom and nurses assisted her to the sitting position. At that point, the patient started having pulmonary froth and the ENT decided to reintubate. Reintubation was accomplished with anesthesia. After intubation, edema rapidly worsened, which required frequent suctioning, and her blood pressure dropped due to the propofol.

**At that point, the patient started having pulmonary froth and the ENT decided to reintubate.**

The patient was deemed not stable enough for ground transport and air transport was called. The patient became bradycardic and asystolic, CPR was started, and a weak, irregular pulse was achieved. She was then taken by ground transport to the hospital. During transport the patient again became asystolic. She was unable to be resuscitated and subsequently pronounced dead.

The family claimed the providers improperly assessed the patient's risk. The procedure should not have been done at an outpatient offsite facility, and the failure to transfer the patient in a timely fashion when she had distress resulted in her death. Ultimately, the total indemnity paid on behalf of the anesthesiologist was \$500,000.



## Case Study #2 Improper Extubation

The patient was a 67-year-old female requiring extensive rehabilitation after a prolonged hospital stay for an anoxic brain injury. Her history included degenerative joint disease with multiple prior surgeries, osteoarthritis, anxiety, hyperlipidemia, hypertension, and hypothyroidism. In early June, the patient was admitted for lumbar laminectomy with posterior lumbar interbody fusion from L2-S1 to be performed by her neurosurgeon.

The CRNA induced IV anesthesia and intubated with an ETT. Shortly after induction, surgery was begun and subsequently completed without complications. The patient was given a final dose of rocuronium. However, there was no documentation of neuromuscular monitoring (“train of four”) to indicate paralytics had adequately been reversed. Within 90 minutes, the patient was suctioned, extubated, and transported to the PACU with an oral airway in place.

In the PACU, there was no admission that vital signs were documented. The patient was then found to be apneic, but the CRNA was unaware of how long she had not been breathing. The patient’s heart rate dropped, and oxygen saturation dropped to 34%. A code was called and compressions started.

**There was return of spontaneous circulation within two minutes and the code ended within seven minutes.**

The anesthesiologist intubated the patient. There was return of spontaneous circulation within two minutes and the code ended within seven minutes. The patient was transferred, intubated, and moved, unresponsive, to the ICU. An MRI showed no evidence of an acute infarction or other intracranial disease. An EEG showed the patient was comatose. Her movements were involuntary, not purposeful, and she did not respond to commands.

Three weeks later, being unable to be weaned off the ventilator, the patient underwent a tracheostomy and a PEG-tube insertion, and transferred to a rehab facility, where she had a very slow recovery. She was eventually weaned off the ventilator, the tracheostomy was closed, and the PEG tube was discontinued.

The patient was discharged to home a month later with residual cognitive, balance, communication, and emotional deficits as a result of anoxic brain injury.

A lawsuit was eventually filed by the patient against the CRNA alleging failure to properly monitor and document the patient’s vital signs, negligent use of Rocuronium, and delayed intubation.

Experts were critical of the CRNA for:

- allowing inadequate time between Rocuronium administration to extubating patient;
- not monitoring respiratory status more closely;
- delaying intubation, and
- using too high of a dose of paralytics.

This case was settled on behalf of the CRNA for \$1,000,000.



## Beyond the Analytics: What Are the Takeaways from the MLMIC-MedPro Group Study for Anesthesia-Related Allegations?

- Practices should conduct ongoing evaluations of the technical skills of their staff and their procedural knowledge and competency with equipment.
- Anesthesiologists must conduct a thorough assessment of the patient preoperatively, and ensure that all testing and specialty evaluations are available for review prior to induction. In an ambulatory setting, these details might not always be as readily available as in the inpatient setting.
- Anesthesiologists must communicate with each other and actively collaborate with other members of the patient's surgical care team, including all operating and recovery room staff, when coordinating the steps of the patient's care, including postoperatively.
- Anesthesiologists must also communicate with the patient (or family), elicit a comprehensive patient history, and conduct a thorough informed consent with the patient that is separate from the surgical consent.
- Anesthesiologists must document their care thoroughly, as the anesthesia record is critically important for detailing the preoperative patient assessment, intraoperative steps, and postoperative sequence of events. Discrepancies or gaps in the details or timing make it much more difficult to build a supportive framework for defense against potential malpractice cases.
- Anesthesiologists must know, and adhere to, their supervision responsibility for advanced practice providers.
- Anesthesiologists must follow patient safety precautions before, during, and after each procedure, including surgical timeouts and the provision of post-anesthesia specialty coverage.
- Chief anesthesiologists should provide in-service education to the physicians who are to supervise the CRNAs. CRNAs need to understand the modalities of anesthesia that will be used in their procedures, be able to determine what medications may need to be ordered both for the procedure and postoperatively, and understand the protocols that are in place should a patient develop complications while under anesthesia. This training should be held at least annually.

**Closing Remarks:** This review of The MLMIC MedPro Group Study and its analytics should provide valuable information on the top anesthesia-related allegations, the top contributing factors leading to anesthesia-related allegations, and the CRNA influence on such allegations, as well as provide anesthesiologists, CRNAs, and other healthcare providers with ways to proactively assess and potentially reduce the risk of such allegations.



**Al Anthony Mercado** is Managing Attorney of the Downstate Region of Mercado May-Skinner, in-house counsel to MLMIC Insurance Company.

[amercado@mlmic.com](mailto:amercado@mlmic.com)

# Update on MLMIC Preferred Savings Programs and Risk Purchasing Groups

MLMIC has added a new offering to its Preferred Savings Program family of discounts: the MagnaCare Risk Purchasing Group (RPG), which offers a 10% discount to qualifying members.

## MAGNACARE<sup>SM</sup>

To be eligible for the MagnaCare RPG, you must be a participating provider in the MagnaCare or Create Network. You can find out more here: [MLMIC.com/magnacare](https://www.mlmic.com/magnacare)

MLMIC's policyholders may change from their current MagnaCare Joint Defense discount to the MagnaCare RPG program as their policy renews and they meet eligibility requirements.

MLMIC's Preferred Savings Program discounts cannot be combined, but they can be included along with the following discounts: Claim-Free, Risk Management, Waiver of Consent, Annual Pre-pay. In addition, the new MagnaCare RPG discount may also be combined with our part-time discount.

Should you have any questions, please feel free to call (800) ASK-MLMIC or visit us online at [MLMIC.com](https://www.mlmic.com). Additional PSP details can be found here: [MLMIC.com/preferred-savings-programs](https://www.mlmic.com/preferred-savings-programs)





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