

Once Seen as Risky, One Group

> Of Doctors Changes Its Ways

> Anesthesiologists Now Offer

> Model of How to Improve

> Safety, Lower Premiums

➤ Surgeons Are Following Suit

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➤ The

> rising cost of medical-malpractice insurance has hit many doctors,
> especially surgeons and obstetricians. But one specialty has largely
> shielded itself:

> Anesthesiologists pay less for malpractice insurance today, in
> constant dollars, than they did 20 years ago. That's mainly because
> some anesthesiologists chose a path many doctors in other specialties
> did not.

> Rather than pushing for laws that would protect them against patient
> lawsuits, these anesthesiologists focused on improving patient
safety.

> Their theory: Less harm to patients would mean fewer lawsuits.

> Over the past two decades, anesthesiologists have advocated the use
of

> devices that alert doctors to potentially fatal problems in the
> operating room. They have helped develop computerized mannequins that
> simulate real-life surgical crises. And they have pressed for
> procedures that protect unconscious patients from potential
> carbon-monoxide poisoning.

> All this has helped save lives. Over the past two decades, patient
> deaths due to anesthesia have declined to one death per 200,000 to
> 300,000 cases from one for every 5,000 cases, according to studies
> compiled by the Institute of Medicine, an arm of the National
> Academies, a leading scientific advisory body.

> Malpractice payments involving the nation's 30,000 anesthesiologists
> are down, too, and anesthesiologists typically pay some of the
> smallest malpractice premiums around. That's a huge change from when
> they were considered among the riskiest doctors to insure.

> Nationwide, the average

> annual premium for anesthesiologists is less than \$21,000, according
> to a survey by the American Society of Anesthesiologists.

> An obstetrician might

> pay 10 times that amount, Medical Liability Monitor, an industry
> newsletter, reports.

> In some areas, anesthesiologists can now buy malpractice insurance
for

> as little as \$4,300 a year, although premiums ranged as high as more
> than \$56,000, according to the ASA. The ASA survey gave no general
> explanation for the disparity but did note that premiums were higher
> for anesthesiologists who had been sued before and for those who
> perform higher-risk procedures.

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> A 1999 report by the Institute of Medicine noted that "few
> professional societies or groups have demonstrated a visible
> commitment to reducing errors in health care and improving patient

> safety."
> It identified one
> exception: anesthesiologists.
> "If there were any specialty where you said, 'Show me who has done
> anything right,' I would point to the anesthesiologists," says Neil
> Kochenour, medical director at the University of Utah Hospitals and
> Clinics. "They have really made some inroads and some impact."
> Medical errors are a leading cause of death in the U.S., killing
> between 44,000 and 98,000 Americans each year, according to various
> studies.
> Medical-malpractice insurance rates for some specialties, such as
> obstetrics and general surgery, have risen in some areas, especially
> in the past few years, as insurers have reported higher paid losses.
> The insurance industry and many doctors groups have blamed greedy
> plaintiffs lawyers and capricious juries for those losses. As a
> remedy, insurers and many medical organizations have pushed for
> legislation that caps damage awards and lawyers' fees. Most states
> have enacted some form of tort reform.
> Many anesthesiologists also support legislative moves to rein in
> malpractice suits. "Even though we've controlled costs, it's still a
> big issue for our membership," says Karen B. Domino, chair of the
> ASA's committee on professional liability.
> But overall, anesthesiologists have put more emphasis on improving
> safety.
> And now, some doctors in other fields are praising them for choosing
> a
> different response. Noting the success achieved by anesthesiologists,
> other doctors -- notably surgeons -- have aimed more at improving
> treatment methods. "There's a lot of room for us to do a better job
> and decrease liability, not just for patient safety but to reduce
> liability [premiums]," says F. Dean Griffen, a surgeon in Shreveport,
> La., who heads the patient-safety and professional-liability
> committee
> for the American College of Surgeons. That professional group
> recently
> launched a study of cases modeled on one that helped
> anesthesiologists
> recognize some of their shortcomings years ago.
> For most of its 160-year history, anesthesiology, the practice of
> rendering a patient unconscious or insensitive to pain, has been
> fraught with danger. As recently as 30 years ago, doctors in the U.S.
> still made patients unconscious by administering ether and other
> flammable gasses. On rare occasions, static electricity sparked
> explosions. Less rarely, patients asphyxiated during surgery because
> their breathing tubes mistakenly became disconnected.
> In 1982, the ABC news program "20/20" aired a piece on
> anesthesia-related deaths. "It was a devastating indictment of
> anesthesia," recalls Ellison C. Pierce Jr., a retired professor of
> anesthesiology at Harvard Medical School who is considered by many to
> be the father of the modern anesthesia-safety movement.
> Around the same time, anesthesiologists were getting hit by their
> second wave of big malpractice-insurance premium increases in a
> decade. The specialty was then considered among the riskiest to
> insure, and premiums were often two to three times as high as those
> other doctors paid. Casey Blitt, a 63-year-old Tucson, Ariz.,
> anesthesiologist who has long been active on patient-safety issues,
> says his insurance soared to \$50,000 a year from \$20,000 or less. Dr.

> Pierce says anesthesiologists were "terrified," and anxious to do
> something.
> Dr. Pierce at the time was president of the American Society of
> Anesthesiologists. In 1985, that group provided \$100,000 to launch
the
> Anesthesia Patient Safety Foundation. The new foundation was unusual
> in
> medicine: a stand-alone organization solely devoted to patient
safety.
> Working closely with the larger ASA, from which it still receives
> about \$400,000 a year, the foundation galvanized safety research and
> improvement.
> Unlike most other medical groups, the foundation admitted as members
> not only doctors but nurses, insurers and even companies that make
> products used by anesthesiologists. Industry's participation
initially
> caused angst over whether the foundation was designed merely to sell
> machines. But over the years, that concern dissipated, Dr. Pierce
> says, as company money helped the organization fund important
> research.
> One advance was the development of high-tech mannequins that allow
> anesthesiologists to practice responses to allergic reactions and
> other life-threatening situations. Anesthesiologists say the
> mannequins have also allowed them to become more proficient at
> performing an emergency procedure akin to a tracheotomy that involves
> slitting open a clogged airway -- something a doctor can't practice
on
> live patients.
> Twenty years ago, little was known about people injured or killed
> during anesthesia. No U.S. database existed, so anesthesiologists set
> out to create one. They decided to collect information from insurers
> on closed malpractice claims, those in which insurers had made a
> payment or otherwise disposed of the complaint.
> Most insurers hesitated to cooperate at first, saying they were
> worried about patient privacy. One company finally agreed:
> St. Paul Fire & Marine
> Insurance Co. in Minnesota said it was concerned about heavy losses
it
> had suffered from anesthesia-related injuries and was eager for
> anesthesiologists to review claims. Soon, other insurers followed
> suit.
> Anesthesiologists left their practices for days at a time to pore
over
> closed insurance claims. The information they collected was fed into
a
> computer at the University of Washington to create an overall picture
> of how anesthesia accidents tend to occur. It "was a humbling
> experience,"
> recalls Russell T. Wall, an anesthesiology professor at Georgetown
> University School of Medicine in Washington, D.C. To date, more than
> 6,400 claims have been analyzed.
> In part by analyzing claims, the anesthesiologists were able to
> document the extent to which patients were dying because of a simple
> mistake:
> Anesthesiologists were inserting the patient's breathing tube down
the
> wrong pipe. Rather than putting it down the trachea, which leads to

> the lungs, they were accidentally inserting it down the esophagus,
> which leads to the stomach. The problem was, there was no way to
> determine quickly whether the tube was in the right pipe. Patients
> often simply turned blue or their blood turned dark. By then, it was
> usually too late to save them.
> The research contributed to two innovations that between them would
> all but eliminate death and injury from "intubation"
> errors. One, known as
> pulse oximetry, measures the oxygen level in the patient's blood
> stream by means of a device that clips onto the patient's finger. The
> other, capnography, measures carbon dioxide in a patient's expelled
> breath, which helps doctors determine at a glance that a patient is
> breathing properly.
> At the time, though, the new technologies had a drawback, Dr. Pierce
> says:
> "It was very hard to get hospitals to buy pulse oximeters and
> capnographs," he says. When they were introduced in the 1980s, the
two
> devices together cost about \$10,000, according to several
> anesthesiologists.
> That's where the safety foundation came in. In 1986, at the urging of
> the foundation, anesthesiologists made the use of pulse oximetry part
> of the ASA's basic standards for anesthesia care. A bit later, they
> added capnography.
> Failing to adhere to ASA recommendations can expose hospitals to
> malpractice liability. By 1990, says Dr. Pierce, almost all American
> hospitals had pulse oximeters and capnographs.
> That change has been accompanied by other less obvious improvements.
> During surgery, a patient's body temperature can fall as
> room-temperature intravenous fluids are infused into the blood. This
> cooling can cause tissue to die and make the body vulnerable to
> infection. The safety foundation funded research on the problem in
the
> 1990s, and now care is taken to keep patients warm during surgery,
> often with specially made blankets that can be heated. Blood and
fluid
> warmers are also used.
> Anesthesiologists also have become much better at preventing patient
> exposure to carbon monoxide. The potentially deadly gas can be an
> unintended byproduct of the process of cleansing a patient's exhaled
> breath of carbon dioxide before the air is recycled back to the
> patient's lungs. One simple way to guard against this problem is to
> make sure that absorbent material in anesthesia machines that filters
> the recycled air remains moist.
> In 1994, the newsletter of the anesthesiologists foundation
documented
> cases in which patients were exposed to high levels of carbon
monoxide
> during surgery on Mondays, presumably after absorbents had spent the
> weekend drying out. The organization recommended replacing the
> absorbent material on Monday mornings and several other changes.
These
> are now standard practice, and rates of carbon-monoxide exposure have
> fallen dramatically.
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> Anesthesiologists are now focused on alarm bells.
> Modern anesthesia

> machines come equipped with audible alarms that sound when certain
> thresholds, such as oxygen levels, are crossed. But the alarms
> irritate many surgeons, so some anesthesiologists have turned them
> off. The foundation has documented 26 alarm-related malpractice
claims
> between 1970 and 2002, or a little more than one a year. Of those,
> more than 20 resulted in either death or brain damage.
> The foundation is pushing to adopt a formal standard that prohibits
> anesthesiologists from disabling the alarms. "I would not fly on an
> airplane if the pilot announced all the alarms were being turned
off,"
> says Robert K. Stoelting, the foundation's current president. "Our
> patients deserve the same safety net."
> Dr. Stoelting, a retired chair of the anesthesiology department at
the
> Indiana University School of Medicine, runs the foundation from
> suburban Indianapolis. He has a two-person administrative staff and a
> relatively modest \$1 million annual budget.
> As anesthesia fatalities have dropped, so has the percentage of total
> malpractice suits filed against anesthesiologists.
> In 1972, according to a
> recent study by Public Citizen, a consumer-advocacy group in
> Washington, D.C., anesthesiologists accounted for 7.9% of all
> medical-malpractice claims, double the proportion of physicians who
> practiced anesthesiology.
> Between 1985 and 2001, anesthesiologists accounted for only 3.8% of
> all claims, roughly comparable to the percentage of doctors who were
> anesthesiologists.
> The size of payments from successful malpractice suits against
> anesthesiologists also has declined. According to the American
Society
> of Anesthesiologists, the median payment during the 1970s was
> \$332,280. By the 1990s, it had dropped 46%, to \$179,010. These
amounts
> are in 2005 dollars and are the most recent figures available.
> Claims for serious injuries have become less frequent. In the 1970s,
> according to the ASA, more than half of anesthesia-malpractice claims
> involved death or permanent brain injury. In the 1990s, that fell to
> less than one-third of claims.
> Malpractice rates for anesthesiologists have gradually fallen, the
ASA
> says. This year, the average annual premium is \$20,572, compared with
> \$32,620 in inflation-adjusted dollars in 1985.
> That's a decrease of 37%
> over 20 years. Malpractice rates are generally set at the beginning
of
> the year.
> Anesthesiologists still make mistakes and aren't immune to recent
> moves in insurance rates. Their annual inflation-adjusted premiums
> have climbed 24% since 2002, when they had dipped to an average of
> \$16,559. Insurers say that overall malpractice rates have risen by
> that amount or more for other specialties during the same period, but
> reliable nationwide figures aren't publicly available. As is done in
> other specialties, anesthesiologists accused of disciplinary problems
> are referred to state licensing agencies.
> Other specialties have noticed how the anesthesiologists have fared.
> Dr.

> Griffen of the College of Surgeons says that more surgeons have begun
> to see a connection between improving patient safety and lowering
> malpractice premiums. The college's closed-claims study so far
> involves about 350 cases, and the group hopes it will grow to 500
this
> year.
> At the University of Utah Hospitals and Clinics, Dr.
> Kochenour says his
> institution has tried to emulate the
> anesthesiologists by concentrating
> more on identifying systemic errors and less on individual blame. But
> these efforts run headlong into thinking drummed into physicians
since
> medical school, he says. "I don't think physicians are very good
> systems thinkers, by and large," he says. Many, especially surgeons,
> prize their independence, he says, and that makes it hard to achieve
> the kind of cooperation necessary to reduce errors.
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