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Non-Operating Room Anesthesia: Closed Claim Review and Analysis

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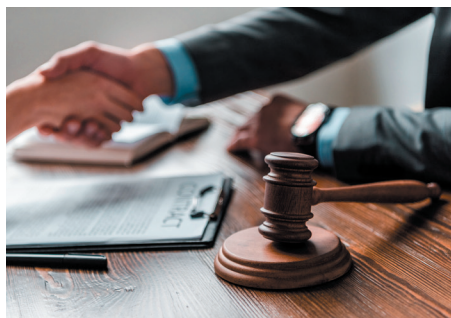
INTRODUCTION

With advancements in minimally invasive procedures and a desire to meet the needs of an ever-changing patient population, anesthesia professionals are increasingly asked to provide services outside the traditional operating room environment.^{1,2} Our medical professional liability company is actively monitoring claim frequency and severity trends relating to adverse events occurring in non-operating room anesthesia (NORA) locations, such as endoscopy units, cardiac catheterization labs, interventional radiology suites, and office-based settings. We recently examined the last 200 claims that resulted in indemnity payments. Of these 200 claims, 28 involved procedures performed in NORA locations. While NORA cases made up only 14% of claims resulting in settlement or judgment, the average payment for NORA procedures was 44% higher than claims originating in the OR. Notably, we found that a higher percentage of paid NORA claims involved catastrophic injuries, such as brain injury and death, than claims arising in the OR.

In this article, we examine a case study and explore some of the unique challenges faced when defending anesthesia professionals in lawsuits stemming from adverse outcomes in NORA locations.

CASE STUDY

A 64-year-old male presented for elective colonoscopy. The patient's medical history was significant for morbid obesity, hypertension, diabetes, and obstructive sleep apnea. The anesthesia plan was intravenous sedation with an unsecured airway. Oxygen was delivered via nasal cannula at a rate of 4 liters per minute. Fifteen minutes into the procedure, the gastroenterologist noted the patient was hypotensive and had an arrhythmia, which developed into bradycardia. When the lights were turned back on, the patient appeared to be cyanotic. His oxygen saturation was 75% and he had a heart rate of 49. The anesthesia professional applied a face mask and increased the oxygen flow to 8 liters per minute. The patient's condition continued to deteriorate, and he went into asystole. A code was called, and the anesthesia professional secured the patient's airway. There was return of spontaneous circulation after several rounds of cardiopulmonary resuscitation (CPR). The patient was transferred to the ICU, where



hypothermia protocol was initiated. A subsequent CT scan revealed diffuse brain swelling. The patient never regained consciousness, and his family elected to withdraw supportive measures. The patient passed away on postoperative day seven.

The patient's wife and adult children filed a lawsuit against the anesthesia professional and his practice group. The family alleged the anesthesia professional departed from the standard of care by (1) oversedating the patient, (2) failing to secure his airway in light of his high risk for obstruction, (3) failing to utilize capnography to measure qualitative ETCO₂, and (4) failing to timely recognize and manage the patient's respiratory depression. Defense experts refuted the allegations pertaining to the depth of sedation and airway support, and these claims gained little traction during the course of litigation. At his deposition, the anesthesia professional testified that he monitored the patient's gas exchange with capnography, but he neglected to document it in the record. While this issue complicated the defensibility of the case, defense counsel indicated it would not be an insurmountable hurdle if the jury found the anesthesia professional's testimony credible. However, the defense later learned that a nurse who witnessed the event was prepared to testify the anesthesia professional did not monitor the patient closely, and that he was showing the nurses pictures on his cellphone during the procedure. Defense counsel reported that the likelihood of prevailing at trial would be substantially diminished if this testimony reached a jury. Accordingly, the parties reached a settlement agreement within the anesthesia professional's policy limits.

CHALLENGES IN DEFENDING NORA CLAIMS

While data suggests NORA patients, on average, are older and more medically complex than the OR patient population,³ our claims experience suggests this data does not align with the general public's perception of the risks associated with NORA procedures. Plaintiffs' attorneys regularly characterize NORA procedures as routine and low risk, contending the most plausible explanation for the adverse outcome was provider negligence. Tens of millions of procedures are performed outside the traditional OR setting annually in the United States.⁴⁻⁶ Based on total volume of NORA procedures performed, many prospective jurors will have undergone a NORA procedure or accompanied a loved one to a procedure. If the procedure at issue was routine and low risk in the jurors' lived experiences, it becomes more challenging to rebut plaintiffs' generalizations and defend cases "on the medicine" with expert testimony.

Moreover, some NORA environments are prone to heightened scrutiny concerning production pressures and economic incentives, particularly in outpatient facilities with high procedure volumes. When a claim involves a code or another emergency, plaintiffs' attorneys commonly examine the facility's staffing and resources to assess whether appropriate personnel, equipment, and rescue medications were readily available. If they uncover any evidence intimating additional personnel or resources could have prevented a crisis or improved the patient's outcome, they will fold these allegations into a basic yet effective theme: economic gain took priority over patient safety.

Another frequent liability theory introduced in NORA claims is that the anesthesia professional failed to adopt proper patient selection criteria or consider alternative anesthesia plans. Plaintiffs' experts, who know the patient's outcome before forming their opinions, review medical records and deposition testimony through the lens of hindsight bias. Anesthesia professionals are often criticized for failing to appreciate the patient was high risk, or that they tailored the anesthesia plan to the facility's practice model rather than the individual patient's needs.

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Lastly, we examined a relatively significant number of the NORA claims in which a proceduralist, nurse, and other provider involved in the patient’s care made disparaging remarks about the anesthesia professional, often alleging the patient’s adverse outcome was attributable to their lack of vigilance. This may be because NORA procedures can be an “away game” for anesthesia professionals. When NORA services are performed in new or unfamiliar settings, other members of the procedure team may be more inclined to point fingers or direct blame at anesthesia professionals if they work together infrequently and have not developed professional relationships.

STRATEGIES TO ADVANCE PATIENT SAFETY IN NORA

The easiest decisions to defend are those that are made in the best interest of the patient’s health and safety. To this end, anesthesia professionals should take sufficient time to perform a comprehensive preanesthesia evaluation and develop an anesthesia plan tailored to the patient based on the individual’s medical history and the nature of the planned procedure. Anesthesia professionals should have autonomy to select the anesthesia plan best suited for the patient, and while the proceduralist may provide input, the anesthesia professional should ultimately make the decision.

Unfortunately, there is no such thing as a risk-free anesthetic, and patients can experience complications even under the safest circumstances. For this reason, anesthesia professionals should dedicate ample time to the informed consent process. It is important that anesthesia professionals highlight pertinent risks and give patients an opportunity to ask questions before the procedure. In the event of a catastrophic complication, professional negligence actions are brought by the patient’s family members,

who may not appreciate there were significant risks associated with the procedure. Accordingly, with the patient’s permission, anesthesia professionals may consider including family members in the informed consent discussion if there is a heightened risk of complication.

Anesthesia professionals should ensure NORA locations have adequate staffing and resources to safely render anesthesia services. Emergency equipment and rescue medications should be properly maintained and readily accessible. In settings where cardiopulmonary arrest is very unlikely to occur, such as dental offices or freestanding endoscopy centers, members of the procedure team may benefit from having defined responsibilities in the event of an emergency. If practical, conducting periodic code simulations at these facilities can ensure the procedure team is better prepared should a real-life crisis arise.

Finally, anesthesia professionals should take the opportunity to get to know the other members of the procedure team when practicing in a new or unfamiliar environment. Everyone involved in the patient’s care shares a common goal: to get the patient through the procedure safely and with the best possible outcome. Anesthesia professionals can reinforce this shared objective by actively communicating with other providers in the room, particularly during critical phases of the procedure, to demonstrate they are focused and engaged in the patient’s care.

CONCLUSION

Thousands of NORA procedures are performed in the United States every day without complication, improving the lives of countless patients in the process. While our closed claims data suggests there is increased liability exposure when major complications occur during NORA procedures, the number of NORA claims as a percentage of total procedures performed

remains small. Additionally, the incidence of NORA claims stemming from minor complications is quite low in our company’s experience. However, when anesthesia professionals are named in lawsuits resulting from catastrophic complications during NORA procedures, they will often face unique challenges defending their care. By better understanding these common allegations and theories of liability, anesthesia professionals can work with other providers and facilities to avoid undue criticism, improve outcomes, and advance a culture of patient safety.

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The author has no conflicts of interest.

REFERENCES

- 1 Wong T, Georgiadis PL, Urman RD, Tsai MH. Non-operating room anesthesia: patient selection and special considerations. *Local Reg Anesth*. 2020;13:1-9. PMID: [32021414](https://pubmed.ncbi.nlm.nih.gov/32021414/)
- 2 Walls J, Weiss M. Safety in non-operating room anesthesia (NORA). *APSF Newsletter*. 2019;34:3-4,21. <https://www.apsf.org/article/safety-in-non-operating-room-anesthesia-nora/> Accessed December 12, 2022.
- 3 Nagrebetsky A, Gabriel RA, Dutton RP, Urman RD. Growth of nonoperating room anesthesia care in the United States: a contemporary trends analysis. *Anesth Analg*. 2017;124:1261-1267. PMID: [27918331](https://pubmed.ncbi.nlm.nih.gov/27918331/)
- 4 Saltzman S, Weinstein M, Ali MA. Patients undergoing outpatient upper endoscopy and colonoscopy on the same day (double procedures) are at increased risk for adverse respiratory outcomes. *Am J Gastroenterol*. 2019;114:307-308. https://journals.lww.com/ajg/Abstract/2019/10001/531_Patients_Undergoing_Outpatient_Upper_Endoscopy.531.aspx. Accessed December 12, 2022.
- 5 Manda YR, Baradhi KM. Cardiac catheterization risks and complications. [Updated 2022 Jun 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK531461/>. Accessed November 15, 2022.
- 6 Urman R, Shapiro F. Improving patient safety in the office: The Institute for Safety in Office-Based Surgery. *APSF Newsletter*. 2011;25:3-4. <https://www.apsf.org/article/improving-patient-safety-in-the-office-the-institute-for-safety-in-office-based-surgery/>. December 12, 2002.