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Oxford Textbook of Anaesthesia for the Obese Patient

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CHAPTER

36 Medicolegal issues and the obese patient

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Abstract

In the United States alone, it is estimated that 15,000–19,000 medical malpractice suits are brought against physicians each year. A retrospective analysis of malpractice claims filed in the United States from 2005 to 2009 uncovered a total of 58,667 claims against American physicians. Of those claims, 96.9% (56,850 claims) were settled with only 3.1% (1817 claims) proceeding to trial. Of those malpractice claims taken to court, obstetrical and surgical claims, as opposed to clinic-based or diagnostic claims, predominated. Although data related to unsuccessful claims which were dropped or dismissed prior to trial or in which findings were in favour of the physician have been difficult to quantify, some authors report that these may comprise as many as 50% of all filed legal malpractice actions.

Keywords: medical malpractice and obesity, obesity-related mortality, obesity-related morbidity, medicolegal

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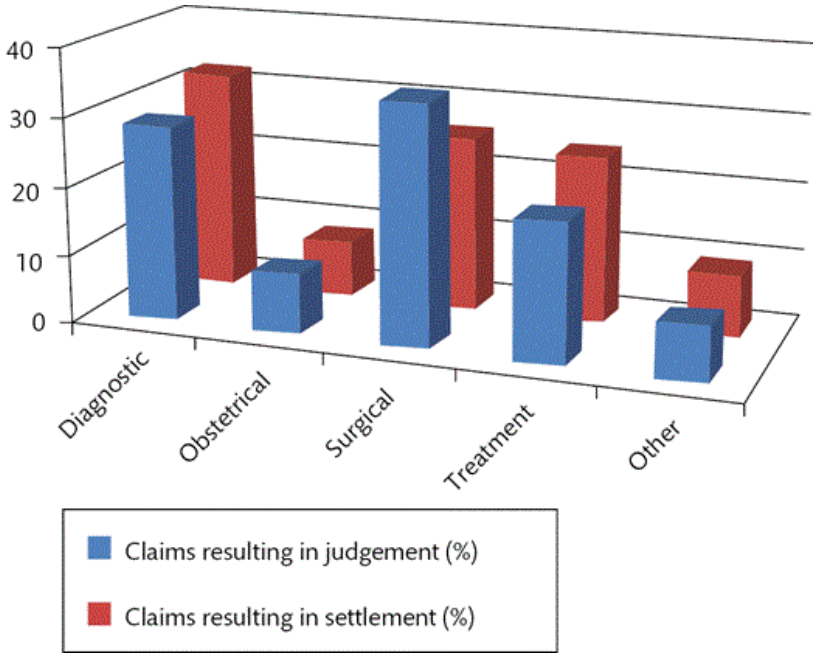
Introduction

In the United States alone, it is estimated that 15,000–19,000 medical malpractice suits are brought against physicians each year [1]. A retrospective analysis of malpractice claims filed in the United States from 2005 to 2009 uncovered a total of 58,667 claims against American physicians. Of those claims, 96.9% (56,850 claims) were settled with only 3.1% (1817 claims) proceeding to trial [2]. Of those malpractice claims taken to court, obstetrical and surgical claims, as opposed to clinic-based or diagnostic claims, predominated [2] (Fig. 36.1). Although data related to unsuccessful claims which were dropped or dismissed prior to trial or in which findings were in favour of the physician have been difficult to quantify, some authors report that these may comprise as many as 50% of all filed legal malpractice actions [3].

Fig. 36.1



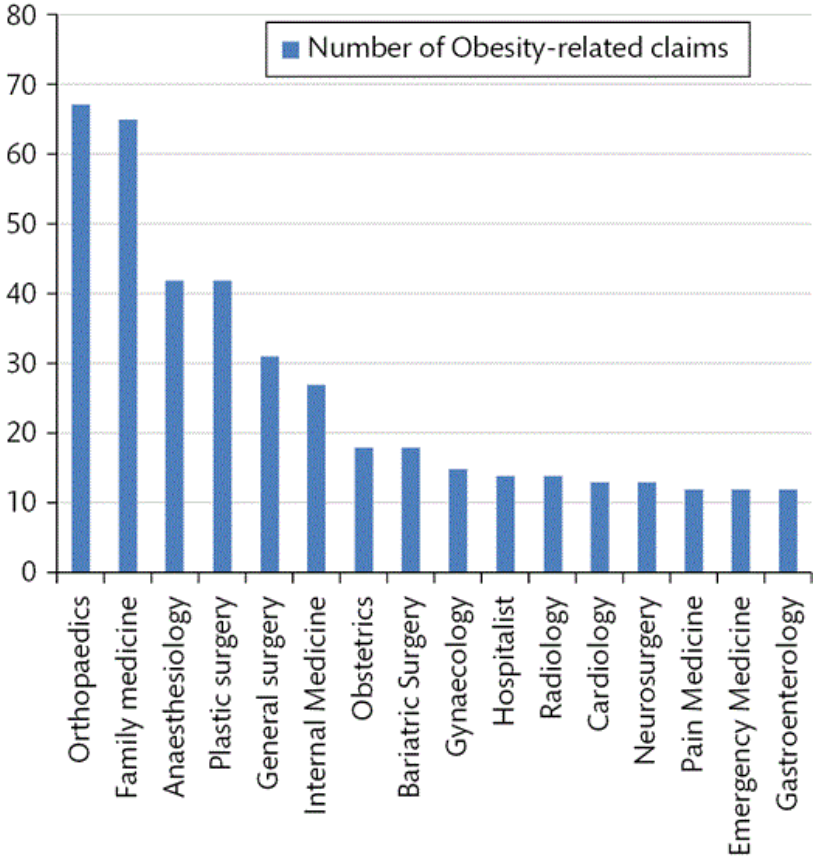
Medical characteristics of claims resulting in judgment and those in settlement.

Source: Data from Rubin, J.B., Bishop, T.F., Characteristics of paid malpractice claims settled in and out of court in the USA: a retrospective analysis, *BMJ Open,* 3(6), 2013, BMJ Publishing Group Ltd.

A lawsuit is a penultimate marker of disruption of the patient–physician relationship. It brings with it an emotional burden including the stigma of malpractice in the form of delivery of poor medical care and/or unethical behaviour on the part of the physician. For the patient, there is long-standing distrust of the medical system as well as any enduring morbidity and mortality. The burden on the system and all parties involved is substantial in terms of time and financial costs.

The process of litigation itself can be negative and overwhelming, and a clear understanding of the process is often lost on all parties [4]. The Doctors Company, a physician-owned malpractice insurance company, conducted a study of its medical malpractice database from 2007 through 2012 [2]. They uncovered a total of 415 obesity-related claims from a variety of specialties [2]. The field of anaesthesiology, which of necessity intersects with the majority of specialties in the operating room, ranked third in the number of claims filed against a specialty provider [2] (Fig. 36.2).

Fig. 36.2

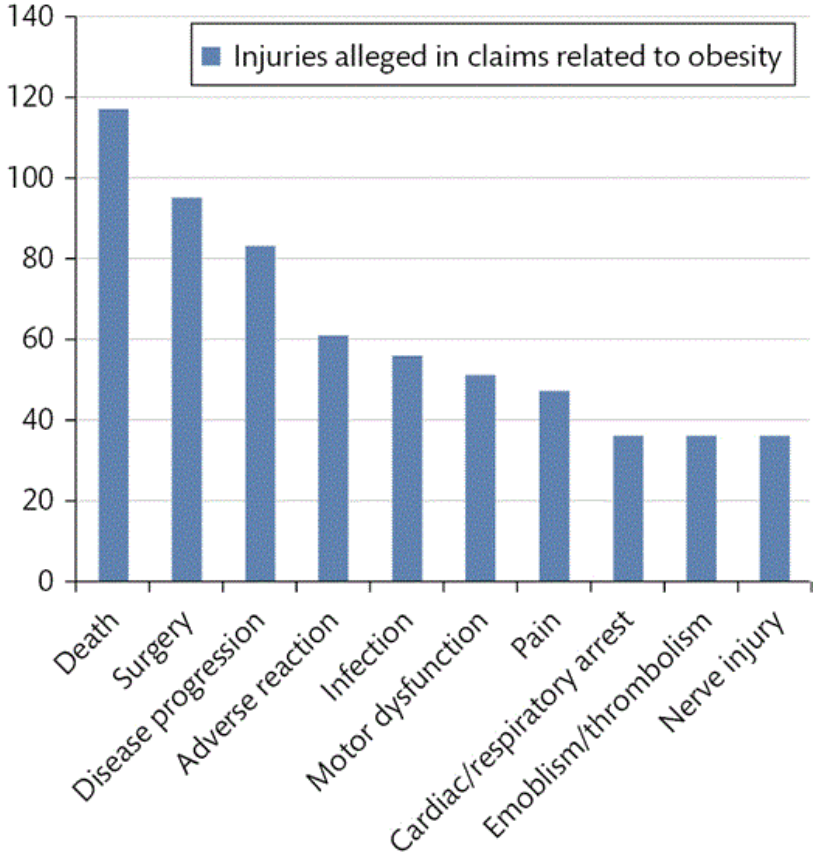


Number of obesity-related claims filed with the Doctors Company from 2007 through 2012.

Source: Data from Doctors Company 'An Overview of Obesity-Related Claims'.

The injuries sustained were significant with the most common injury being death in 25% of the claims filed [2] (Fig. 36.3).

Fig. 36.3



Injuries alleged in claims related to obesity filed with the Doctors Company from 2007 through 2012.

Source: Data from Doctors Company 'An Overview of Obesity-Related Claims'.

Principles of medical malpractice claims

Tort law principles

Legal principles define a tort as a civil wrong committed against a person or his or her property. A tort is independent of any contractual obligation owed to that person. The tort may be based on the violation of either a public or private duty or a legal right [5]. In medical malpractice, a tort may occur through wilfulness, negligence, or lack of skill. The tort may be grounded in an entire course of treatment or a single act [6].

To satisfy the requirements of a cause of action, the plaintiff must demonstrate:

a. A duty on the part of the physician/defendant

b. A breach of that duty

c. The physician's breach as the proximate cause of the plaintiff's injuries

d. Damages incurred [7,8].

A duty owed

To demonstrate a medical malpractice claim, the plaintiff has to establish the existence of a plaintiff–doctor relationship. This includes evidence of intent by both parties to enter into this professional relationship. This relationship does not need to be based on a contract. Moreover, the physician does not need to be compensated in order to owe a duty to the patient [7,9]. A doctor who undertakes a patient's treatment for free owes a duty to that patient just as if he or she were to be paid. The Good Samaritan doctrine is an exception to this rule. A physician may volunteer in good faith to respond to an emergency without assuming a duty to the patient. However, the Good Samaritan doctrine itself may be trumped where that doctor is summoned to aid another doctor who does have a duty to the patient [10].

Breach of duty

A physician is expected to perform with the degree of skill, learning, and care that is expected of an average qualified member of their profession. Based on state requirements, the average physician against whom the physician is compared may be defined by regional or by national standards. Where the physician represents him- or herself as the best in the field, the standard is elevated to meet that claim.

Proximate cause of injury

The plaintiff must demonstrate that the defendant caused his or her injury [11]. The fact that another physician had the opportunity to correct a negligent act is not protective [12].

When several physicians are involved in the management of a case, they are responsible not only for their own mistakes but for the errors of others which they permitted to occur without objection and of which they should have been aware [13].

Damages

The plaintiff must show damages to sustain an action of medical malpractice [14]. When there is no harm or damage, there can be no cause of action. Damage awards may be compensatory or punitive in nature [5]. Compensatory damages awards are intended to reimburse a loss suffered. Punitive damages are awarded to punish and make an example of the defendant for outrageous acts and are awarded above and beyond compensatory damages [5].

Only where each of these elements is demonstrated may a patient prevail in a cause of medical malpractice.

Medical malpractice in patient-specific scenarios

There are several areas within the field of anaesthesiology where medical malpractice has had a significant impact on practice patterns. In all these areas, even when obesity is not directly a factor, the lessons and concerns remain and may be extrapolated.

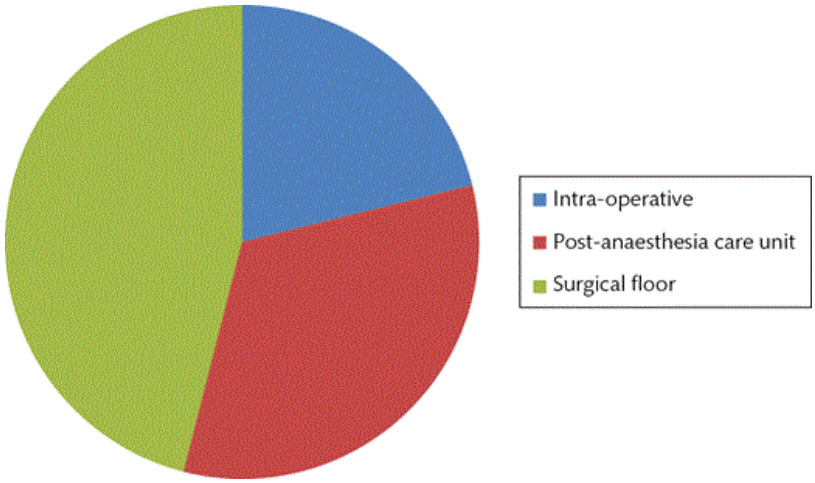
Obstructive sleep apnoea

The obesity epidemic combined with population longevity has led to the growing prevalence of obstructive sleep apnoea (OSA) within our communities. Surgical patients with either known or suspected OSA are at a heightened risk for perioperative morbidity and mortality [15,16].

In 2016, Fouladpour et al. studied the legal consequences associated with poor outcomes related to OSA in the perioperative setting (Fig. 36.4) [1]. They performed searches of three major electronic legal databases for cases adjudicated and with a final decision rendered between 1991 and 2010. The cases all involved surgical patients with known or suspected OSA. Paediatric cases were excluded. Their research uncovered that 92% of those lawsuits were based on elective cases [1]. Almost half of the complications (46%) occurred in the postoperative period on the surgical floors [1], with the fewest complications occurring intraoperatively (21%).

p. 341

Fig. 36.4



Location of complications sustained by adult surgical patients suspected of or diagnosed with obstructive sleep apnoea.

Source: Data from Fouladpour, N., Jesudoss, R., Bolden, N., Shaman, Z., Auckley, D., Perioperative Complications in Obstructive Sleep Apnea Patients Undergoing Surgery: A Review of the Legal Literature, *Anesthesia & Analgesia,* 122(1):145–51, 2016 International Anesthesia Research Society.

The most common complications were respiratory arrest in unmonitored settings and difficulty in airway management [1]. Immediate adverse outcomes included death (45.6%), anoxic brain injury (45.6%), and upper airway complications (8%). Overall, 71% of the patients died [1]. Verdicts rendered were almost evenly split with a slight predominance in favour of the plaintiff. In those cases in which the plaintiff prevailed, the average financial penalty was US$2.5 million [1].

Perioperative complications related to OSA constitute a growing number of medical malpractice actions. The actual medical, legal, and financial burden is underestimated as most suits are settled out of court.

The paediatric patient

Sleep-disordered breathing and sleep apnoea are often associated with obesity in the paediatric patient [17,18]. Sleep-disordered breathing also constitutes the most common indication for tonsillectomy resulting from airway obstruction [19,20]. The push to conserve medical resources and cost, combined with improving medical techniques, has resulted in an increasing number of these procedures being performed on an outpatient basis. This decreases the number of circumstances in which the anaesthesiologist is able to meet the patient prior to the day of surgery and to observe the patient postoperatively [21]. Tonsillectomy-related malpractice settlements are more common against anaesthesiologists than against surgeons, settling for almost fivefold greater awards due to devastating outcomes [22,23,24]. Anoxic intraoperative and postoperative events in the paediatric patient have accounted for verdicts as large as US$45 million [21].

Coté et al. analysed data obtained from the American Society of Anesthesiologists Closed Claims Project and an electronic survey performed on more than 2000 members of the Society of Pediatric Anesthesia, identifying adverse events during or after tonsillectomy in children. The cases reported by surgeons and anaesthesiologists included death or neurological injury as complications following tonsillectomy. It appeared that many of these incidents may have been prevented if respiratory monitoring had been continued during first- and second-stage recovery, as well as on the ward during the first postoperative night. This emphasizes the need for better evaluations and procedures for assessing perioperative risks after surgery in the paediatric patient, in particular, those patients with OSA [21]. Literature also demonstrates that the combination of obesity, OSA, and the need for postoperative opioids significantly increases the potential for adverse postoperative respiratory events in the paediatric patient, creating an increased risk of airway obstruction on the first night of surgery when compared to the preoperative risk, especially those undergoing tonsillectomy with or without adenoidectomy [25,26].

The parturient

Obstetric anaesthesia is an integral part of practice for most anaesthesiologists. For both obstetricians and anaesthesiologists, this area of practice carries a high liability burden [27,28].

Beckmann studied the influence of medicolegal aspects of obstetric anaesthesiology on anaesthetic practice in Australia and New Zealand. Information regarding medical defence organizations and opinions about the current medicolegal trend and demographics were analysed. A total of 95.3% of members of the Australian and New Zealand College of Anaesthetists were concerned about the existing medical indemnity climate and 73.6% expected to have at least one claim against them during their career, spending an average of 8.3% of their income on medical insurance premiums [29]. The study also uncovered that following the preoperative consultation, physicians often made changes to their anaesthetic plan. Some of the changes evidenced a prevalent and growing reluctance to perform neuraxial blocks. Physicians had also become more thorough in their documentation of complications [29].

A study conducted by Crawforth evaluated the anaesthesia care provided during adverse events on the obstetric ward. Malpractice claims filed against nurse anaesthetists for care involving obstetric patients were extracted from the American Association of Nurse Anesthetists Foundation Closed Claim database (N = 41). They included events which occurred between 1990 and 1996 and represented anaesthesiology care provided by both anaesthesiologists and nurse anaesthetists. The most prevalent risks factors identified in this study were advanced maternal age and obesity [30].

Treating patients with respect

As anaesthesiologists, we are obligated to discuss with all patients their health issues and associated perioperative risks. Obesity is one such comorbidity. Patients should be counselled in the course of the consent process regarding the impact that their obesity and/or any associated comorbidities may have on their anaesthetic management and care. The consent process should be well documented to reflect the discussion had with the patient.

Issues of professionalism also play a key role in patient care. Patients suffering from obesity perceive weight discrimination as a component of their care with negative ramifications [31]. The negative consequences include not only higher rates of psychiatric conditions, such as depression, but a cycle that includes poorer success at weight loss [32].

In 2013, a patient scheduled for a colonoscopy recorded on his mobile phone conversations occurring between the medical staff and physicians while he was anaesthetized. The mobile phone recordings captured the anaesthesiologist ridiculing and humiliating the patient while he was under her care. The
p. 342 verdict returned in favour ↳ of the patient of $500,000 for malpractice, defamation, and punitive damages [33]. Physician attitudes and behaviours play an integral part in both patient care and expectations of professionalism.

Recommendations for the anaesthesiologist

The practice of anaesthesia is a complex discipline that requires a constantly evolving body of knowledge, techniques, and interpersonal skill. An analysis performed in 2013 of over 40,000 physicians cited anaesthesiology as the specialty with the third highest number of open claims [34]. A 2012 study reported that anaesthesiologists feared both financial ruin and the effect on professional reputation among colleagues and patients [35]. This fear persists although some estimate that as many as 80% of malpractice claims settled by jury find in favour of physicians.

Medical malpractice litigation has affected the practice of medicine in all specialties increasing the cost of healthcare in the United States due to direct costs of litigations, the practice of defensive medicine, and a rise in malpractice premiums [36]. This increase is estimated to be in the order of billions of dollars [37]. These sums do not include the social and emotional costs of litigation on the patient, the physician, and society.

It is critical that at a baseline, anaesthesiologists establish respectful relationships with their patients both when the patient is conscious and anaesthetized. Honest interactions with the patient should include a discussion of the anaesthetic risks associated with obesity when applicable. This allows patients to have reasonable expectations regarding possible outcomes prior to engaging in an intervention. The discussion should be well documented particularly where the risks involved are evident. Ensure that the patient is aware of the risks and benefits of the procedure. In the effort to reassure the anxious patient, be certain not to make assurances that cannot be guaranteed. Never be reticent to seek help when needed. In the event of an adverse outcome, contact your risk management team as soon as possible.

Case report

A 42-year-old, 178 cm, 213 kg (BMI 67 kg/m^2) male patient presents for arthroscopic shoulder surgery at the ambulatory surgery centre. His prior medical history includes hypertension, diabetes mellitus, OSA, dyslipidaemia, and degenerative arthritis. The patient is non-compliant with his continuous positive airway pressure mask because he ‘can’t sleep with the mask on’. His airway exam shows a large patient in relative comfort with a Class III Mallampati exam, a neck circumference of 46 cm, and a full beard. His laboratory values are unimpressive except for an apnoea–hypopnoea index of 60. The surgeon plans to place the patient lateral, because that is how he ‘always’ does his cases.

The anaesthesiologist is hesitant to upset the surgeon or patient by cancelling the case. The case proceeds to the operating room where the anaesthesiologist fails to intubate the patient with an endotracheal tube and places a supraglottic airway device. The case then proceeds with the patient breathing spontaneously in the lateral position. At the conclusion of the case, the patient is placed supine and extubated. Shortly thereafter, the anaesthesiologist notices that the patient is no longer breathing. The anaesthesiologist is unable to place any airway device back in the airway. The patient becomes hypoxic, develops a cardiac arrest, is ineffectively coded, and suffers anoxic brain injury. Two days later the patient’s care is withdrawn.

The patient’s family sues the anaesthesiologist, the surgeon, and the facility. The case is settled against the anaesthesiologist for a very large sum.

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