Risk Management Review

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

5814 Reed Road, Fort Wayne IN, 46835 | 800-4MEDPRO | www.medpro.com

Patient Withholds Medical History Information, Resulting in Anesthesia-Related Death

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

An integral part of oral and maxillofacial surgery (OMS) is the administration of anesthesia to achieve patient comfort during complex and often extensive procedures. To administer the proper anesthetic agent in the correct dosage, the oral surgeon must consider certain factors, such as the patient's medical history.

This interesting case from the Midwest illustrates what can happen when a surgeon has incomplete information about a patient's medical history.

Facts

The patient was a 51-year-old male who had a medical history of morbid obesity, sleep apnea, diabetes, and hypertension (which was controlled with medication). He presented to Dr. A, an oral surgeon, for extraction of teeth 31 and 32. (Tooth 31 was abscessed, and tooth 32 was impacted.) Dr. A classified the patient as ASA PS 3 based on his medical history and decided that the extractions would need to be done at a hospital.

The patient was not happy with the prospect of hospital treatment, so he subsequently consulted with Dr. B for a second opinion. When Dr. B asked essentially the same medical history questions, the patient withheld the fact that he had hypertension and sleep apnea (requiring the daily use of CPAP). As a result of this less complete information, Dr. B classified the patient as ASA PS 2 and concluded that it would be appropriate to do the procedure in the office, under conscious sedation.

The patient was sedated with Brevitol®, and the surgery was completed without difficulty. However, at the end of the surgery, the patient could not be aroused. He initially had a pulse, but it quickly diminished and then stopped completely. Resuscitation was commenced, and EMS

was called. However, the patient's pulse was never restored, and he expired in the hospital emergency department.

A lawsuit was brought against Dr. B and the registered nurse who had administered the anesthesia and monitored the patient. The suit was settled prior to trial by a payment on behalf of the doctor in the midrange; expenses were in the high range.

Discussion

In discussing this case, it is important to explain why it was settled, given that the patient withheld very important information from Dr. B.

A person could reasonably argue that Dr. B might have classified the patient as ASA PS 3 and insisted on treatment in a hospital setting if he had known the patient's complete medical history.

However, three factors made it necessary to settle this case. First, Dr. B's documentation of this case was inadequate, particularly in relation to the ASA classification level. Because this case was known to have a catastrophic outcome, the poor documentation is particularly hard to understand.

Second, both Dr. B and the registered nurse who administered the anesthesia and monitored the patient were quite elderly. Dr. B had an unusually poor deposition, for which his age may have partially played a role. He apparently had suffered some memory loss between the time of the case and his deposition, resulting in several major inconsistencies between his and the nurse's deposition testimony.

Unfortunately, between the time of his deposition and the trial, Dr. B suddenly and unexpectedly died. Because of this, only Dr. B's deposition testimony was available to defend the case. In the defense counsel's opinion, this testimony, combined with the poor documentation, prevented adequate defense of the care that was rendered.

An unstated, but important final factor to consider is a legal concept known as *res ipsa loquitur*, which is Latin for "the thing speaks for itself." This principle states that negligence can sometimes be inferred due to the nature of the injury, even if direct evidence is not available. In this case, the defense had to overcome a jury mindset that it is reasonable to expect not to die in the process of receiving treatment for impacted molars.

These factors, taken in totality, made settlement the best option.

This case is, nevertheless, valuable from a risk management standpoint, as it illustrates several important patient care principles. The first issue in this case is the inadequate documentation of the ASA assessment. Because these assessments

involve a certain amount of subjectivity, it is wise to document in sufficient detail the factors that justify assessment at a certain level.

Additionally, when a suboptimal result occurs, the documentation should be as complete and precise as possible. Even in young minds, memories fade, but the documentation will not change.

The next issue in this case was the patient's medical history. Although it is not uncommon to encounter general dentistry cases in which a patient's history has not been updated in several years, this is much less common in OMS because of the episodic nature of care.

The medical history serves several purposes. First, it establishes the patient's suitability for treatment. For example, when allergies, comorbidities, and behavioral factors (e.g., smoking or chronic alcohol consumption) are considered, is the patient an appropriate candidate for this treatment, in this location, and at this time?

Second, taking the patient's medical history establishes the treatment starting point and identifies any pre-existing conditions. Although the oral surgeon is not responsible for pre-existing problems (such as TMJ complications), he or she should carefully document these issues in the patient's record.

Finally, gathering information about the patient's history gives the oral surgeon a chance to get to know the patient, including the patient's fears, expectations, or other misconceptions. After all, many, if not most, OMS patients are new to the practice.

The last aspect of this case to discuss is the provision of emergency care. Although the caregivers may have been a little slow in identifying the patient's deteriorating condition (especially the registered nurse, who was tasked with monitoring the patient), nothing indicates that the emergency care was less than adequate once the patient's condition was identified.

Oral surgeons are very well trained to recognize and treat medical emergencies, and appropriate resuscitative equipment is normally on hand. However, staff members who have not had much (if any) formal training in managing emergencies are a potential weak link.

Oral surgeons would be wise to provide their staff members with regular training in emergency medical management, including conducting simulations (preferably in the office). Experience has shown that people respond to emergency situations consistent with the training they have received. As such, thorough and timely training may significantly increase the likelihood of a favorable outcome.

Summary Suggestions

The following suggestions may help oral surgeons who are assessing and treating patients who have systemic anesthesia:

- When doing an ASA assessment, carefully document the clinical factors or conditions that lead to the selected classification level.
- Ensure thorough documentation of each case, which can be valuable in treating the patient in the future, communicating with other healthcare providers, and defending any allegations of negligent care.
- Carefully monitor patients both during and after procedures in which systemic anesthesia is used. Careful monitoring will provide an opportunity to intervene quickly if the patient begins to decompensate.
- Ensure that healthcare providers and staff in the OMS office are knowledgeable and well-practiced in responding to medical emergencies.

Conclusion

The administration of anesthesia in the OMS office is safer and more efficacious than ever before because of a variety of new medications, ever-improving administration and monitoring equipment, and a knowledge base that constantly increases. Adherence to the recommendations discussed above should help support good patient safety practices.