Managing the Untoward Anesthetic Event in an Oral and Maxillofacial Surgery Practice

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KEYWORDS
- Anesthesia certification • Untoward anesthesia event • Emergency medicine protocol
- Professional liability • Apology • Second victim

KEY POINTS
- There has been a significant increase in the number of outpatient surgical procedures and administration of sedation/anesthesia in the United States, resulting in a greater risk of an untoward anesthesia event.
- An untoward anesthesia event must be reported to the practitioner’s professional liability insurance carrier and State Board of Dentistry/Regulatory agencies as soon as possible after such events.
- Compliance with training programs and familiarity with established emergency protocols are essential for all oral and maxillofacial surgery (OMS) staff involved with patient care.
- Disclosure of information associated with an untoward anesthetic outcome, as well as the apology that is often appropriated after such an event, should be discussed with the OMS’s counsel.
- A cataclysmic patient injury or death can lead to significant emotional distress for the oral maxillofacial practitioner and their team, which can potentially lead to significant and permanent psychological limitations.

Dentistry through the legacy of Horace Wells, DDS and William T.G. Morton, DDS has a rich history in the administration of anesthesia to alleviate pain and anxiety. For oral and maxillofacial surgeons, the administration of sedation and general anesthesia in the office setting has been a hallmark of the specialty for many decades. The safe and efficient use of outpatient surgical anesthesia modalities is a significant part of the training and expertise of the oral and maxillofacial surgeon.1–7

The most recent anesthesia morbidity and mortality data reported by the Oral and Maxillofacial Surgeons National Insurance Company (OMSNIC) from 2000 to 2011 show that the average oral and maxillofacial surgeon performs 669 office anesthetic procedures per year, of which 71% are general anesthetics and 29% are sedation anesthetics, for a total of 33,191,562 cases over the 11-year period. Ninety-one in-office cases of death and brain damage were reported, along with 33 cases of hospital death and brain damage for a total of 124 cases and an average in-office mortality rate of 1 per 364,742. According to this report, the average oral and maxillofacial surgeon will perform 20,070 in-office anesthetics over a 30 year period. Considering a mortality rate of 1/364,742, these data suggest that 1 in 18 oral

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and maxillofacial surgeons will experience an in-office death over their career, and as this report accounts for 49,581 oral and maxillofacial surgeon years, it can be extrapolated that 1 in 545 oral and maxillofacial surgeons will experience an office anesthetic death per year.8

The experience of the oral and maxillofacial surgery (OMS) practice and the administration of sedation/anesthesia during ambulatory surgery reflect an excellent safety record. Over the life of an OMS practice, there is a small but definable chance that an untoward anesthesia event (UAE) will occur, placing all oral and maxillofacial surgeons performing outpatient anesthesia at risk of experiencing a UAE resulting in cataclysmic injury to the patient or death. Although adverse outcomes are rare, they can have considerable traumatic psychological and professional consequences for the surgeon involved. Although oral and maxillofacial surgeons are highly trained in the management of the airway and managing complications and emergencies associated with the administration of anesthesia, this training does not prepare them to handle the aftermath of an untoward outcome or adverse event. Unfortunately, when bad outcomes do occur there are 2 sets of victims. The first set of victims and the most affected is the patient and the families. The doctor is the second victim suffering from the same bad outcome, having to deal with devastation, pain, frustration, overwhelming stress and anxiety negatively affecting their health and interpersonal relationships.9 Bad outcomes do occur to good doctors who are good practitioners and when things go wrong it may or may not be to the result of negligence. It is not uncommon for the doctor to experience a long and extremely stressful legal process involving complex interactions with attorneys, courtrooms, and juries. Ironically, as surgeons, we have well-established guidelines and procedural algorithms for our surgical and anesthesia practice but no such guidelines to follow to help us deal with crisis management if we encounter a bad outcome. There is little written in the literature to guide us through the misfortune of an adverse outcome. The goal of this article is to develop guidelines to educate the doctor, the second victim, on how to manage a bad outcome and how to navigate through a difficult and arduous process.

CERTIFICATION FOR ADMINISTRATION OF SEDATION/ANESTHESIA

Within the United States, the practice of OMS is regulated by each state’s Dental Practice Act, which sets out the requirements for certification for the administration of the various levels of sedation and anesthesia. The certification process involves an application and the provision of credentials and/or additional training to be confirmed by the appropriate certification. It is not expected that an oral maxillofacial surgeon will require a significant amount of additional education or training based on the amount of anesthesia training provided within OMS residency programs in North America. It is important that the oral maxillofacial surgeon is cognizant of the training requirements for the OMS team.

It is imperative that each practitioner in the OMS is current with their Advanced Cardiac Life Support (ACLS) certification and that the requisite emergency monitoring and resuscitation equipment, pharmaceutical agents, current permits, and so forth are maintained. In addition, many states require inspection of the ambulatory facility in which the sedation/anesthesia is to be administered. The regulatory inspection of the facilities may be performed on an annual basis or by unannounced inspections. The OMS practitioner must be aware of the requirements for the display of appropriate state Department of Health and Board of Dentistry certification documents.

MEDICAL EMERGENCY RESPONSE OFFICE PROTOCOL

Each OMS office must maintain a medical emergency response office protocol document (the Protocol) outlining, with specificity, the procedures for responding to the occurrence of an UAE or other medical emergency. This Protocol must include documentation of regular medical emergency response office education and training including practice sessions and unannounced emergency response drills. The documentation must include the date, time and names of the OMS team participants present for the emergency training, and the documentation of attendance must be dated and signed by all participants. The Protocol must contain certification that each member of the OMS team has received requisite training in medical emergency response, ACLS certification, has maintained said training and is up to date with all required credentials. Copies of the certification for continuing education programs necessary for maintaining the office certification for sedation/anesthesia administration should be maintained as part of the Protocol document. The Protocol document must contain the specific delegation of medical emergency response duties and responsibilities for each member of
the OMS team. Each member of the OMS team must be aware of, trained, and examined in their specific duties in the event of a medical emergency. The following are essential components of this protocol outlining specific team member responsibility:

- The Protocol must include specific designation of the team members who are to assist the oral maxillofacial surgeon with the direct ventilation/resuscitation efforts on the patient.
- The Protocol must specify which members of the OMS team are responsible for documentation of the patient’s vital signs, including O₂ saturation, heart rate, blood pressure, respiration, skin tone, pallor, and any other signs of distress. It is imperative to designate 1 or more members of the OMS team specifically to document, in hand written notes or on the electronic health care record, the patient’s vital signs, the type, time, and duration of all manner of ventilation/resuscitation efforts, and must include the time, amount, and route of administration of pharmaceutical agents, and the patient’s response to said efforts.
- The Protocol must designate 1 or more members of the OMS team who is specifically designated to contact the emergency medical services/911 (EMS) when instructed. The time of the telephone contact must be documented in the clinical records. It is important that the OMS team member so designated is level headed and clear when imparting the requisite information to the EMS team. In addition, the OMS team designee should be instructed to remain on the telephone with EMS dispatch to maintain contact with the EMS vehicle while it is en route. An OMS team member should be designated to be stationed outside the entrance of the office to direct EMS personnel to the correct room in the most expeditious manner.
- Each member of the OMS team who has designated duties must have a specific backup personnel designated for all emergency procedures should there be a change in personnel, absences, sickness, and so forth. It is imperative that as changes in the OMS team occur the team members’ duties must be redesignated accordingly. Continual education and training sessions are a must.
- The Protocol document must include details of the maintenance of all anesthesia, sedation, ventilation/resuscitation equipment, medications/pharmaceutical agents, and so forth. It is imperative that this document is complete and up to date.

CLINICAL DOCUMENTATION

Before the initiation of sedation/anesthesia administration, a medical history must be completed, updated and reviewed by the oral and maxillofacial surgeon. The medical history form must be completed by the patient and should be witnessed by an authoritative member of the OMS team or the surgeon. There must be documentation of discussion with the patient concerning their medical history before the initiation of any administration of sedation/anesthesia including documentation of their American Society of Anesthesiologists (ASA) classification. The clinical documentation must include the fact that written preanesthesia and postanesthesia instructions were provided. If necessary, the fact that the patient was to be nil by mouth (NPO) for a requisite time period must be documented as well as the name and the relationship of the person/attendant who is responsible for the patient after the completion of the procedure.

The attendant is to bring the patient to and from the appointed procedure and is instructed that, during anesthesia recovery time, the patient should not drive or operate complicated machinery/devices, make important decisions, execute documents, and so forth.

The surgeon’s treatment plan must include a specific list of the procedures that will be performed, which includes the correct Current Dental Terminology (CDT)/Current Procedural Terminology (CPT) code for the sedation/anesthesia procedure that is planned. In addition, the Ambulatory Anesthesia Report must be fully completed with all requisite information including confirmation of the correct date and the names of the personnel who are assisting in the procedure. For each sedative/anesthesia agent that is administered, the amount and time of administration must be stated and must be noted contemporaneously on the anesthesia report. All documentation for emergency and resuscitation efforts must be detailed with specificity including the time, personnel, patient response, and the time of notification of EMS/911. The vital signs monitor displays the patient’s vital signs, but in some cases, the information can be lost if the monitor is turned off before the information is printed. There have been cases when vital signs monitoring equipment was turned off by EMS personnel after entering the surgical suite and none had the forethought to print the information or to document the clinical information. If the information contained within the vital signs
monitor is lost, this has a significant impact on any subsequent investigation.

**INFORMED CONSENT**

Before any surgical procedure, the surgeon and the patient/patient’s guardian must engage in the surgical procedure informed consent discussion process. In addition, a separate sedation/anesthesia informed consent discussion process must be completed. As part of the sedation/anesthesia informed consent discussion process, the patient must be provided with the requisite information to allow them to make an informed decision concerning the administration of the sedation/anesthesia that is scheduled.

The information provided to the patient during the sedation/anesthesia informed consent discussion must include an explanation of the parameters of the sedation/anesthesia procedure planned including the type of agent, the route of administration, and so forth. A discussion of all reasonable alternative sedation/anesthesia modalities available must be included; which also includes the option of having no sedation/anesthesia. The discussion must include all the material risks that may occur during the administration of sedation/anesthesia as well as the recovery phase. The informed consent process must include a discussion of the necessity of having a responsible adult attendant to transport the patient, respond to postoperative instructions including fulfillment of prescriptions, and ensure that the postanesthetic patient refrains from any analytical or complicated activity until fully competent. The adult attendant’s name and contact information should be placed in the clinical documentation.

At the completion of the of the surgical procedure and sedation/anesthesia informed consent discussion processes, the discussions must be confirmed in writing, signed by the patient and/or their guardian, dated, signed by the person who is performing the surgical procedure and sedation/anesthesia, or dated and signed by an adult competent witness.

The clinical documentation must contain a statement confirming that the sedation/anesthesia informed consent discussion took place, that the patient/guardian had the opportunity to ask questions, and that all questions were responded to and understood by the patient. In the authors’ experience, informed consent documents in which each paragraph of separate information is numbered with a box for the patient to initial to confirm that they have read and understood the information seem to be received better by a jury. Examples of informed consent process documentation forms are available from OMSNIC.

**EMERGENCY MEDICAL SERVICES**

While the EMS/911 personnel are being contacted, the surgeon and the team must continue to stabilize the patient. When the EMS/911 personnel have entered the outpatient facility/op-eratory and have assumed responsibility for the care/treatment/resuscitation efforts on the patient, documentation of the EMS efforts should be continued by a member of the OMS team. If the surgeon is not assisting with the resuscitation efforts, he or she should continue to document said efforts either directly in the clinical records or on a separate piece of paper to be placed in the clinical record/electronic health record at a later time.

It is important that the EMS/911 personnel are provided with all the information concerning the preoperative patient medical history, amounts, type, and route of administration of anesthesia/sedation agents, the patient reaction, description of the surgical procedure, whether completed or not, and any other relevant information. The information provided to the EMS/911 personnel should also include the patient’s medical history and any salient information regarding allergies, syndromes, Mallampati score/airway issues, medication that the patient is taking, and so forth.

A specific description of the UAE should be provided to the EMS/911 personnel when transferring control of patient care and should include a description of the clinical procedure that was being performed, the specifics on the anesthesia (all drugs administered, amount, types, times, route of administration), and a specific explanation of the ventilatory resuscitative efforts performed on the patient and the patient’s response. If the surgeon is assisting the EMS/911 personnel in the resuscitation of the patient, the surgeon may be requested to accompany the EMS/911 and the patient in the emergency transport vehicle. If not, another member of the OMS team may be requested to accompany the EMS/911 and the patient in the emergency vehicle.

A member of the OMS team must be assigned to provide information to the person/persons who accompanied the patient to the OMS office. Only objective information concerning the patient’s condition should be provided during the stabilization process and the patient’s attendant should not be allowed to witness the emergency resuscitative efforts. The OMS personnel providing this information must do so in a discreet manner so as to not generate concern in other patients present in
the reception area. Be cognizant of the fact that any information that is provided to a third party can be misinterpreted/misunderstood and could be used in a subsequent Department of Health/Board of Dentistry investigation or civil litigation.

**HOSPITAL EMERGENCY DEPARTMENT**

The surgeon should be present at the hospital emergency department (ED) where their patient is transported to provide any information requested by emergency personnel. This may include information previously provided to EMS personnel that may require clarification. An OMS team member may be assigned to accompany the patient’s family member/attendant to the ED.

While the OMS team is at the ED, they will likely be in a reception/waiting room area with the personnel who accompanied the patient to their OMS appointment. The OMS team should attempt to respond to inquiries by the patient’s family/friends in a calm and objective manner. Be cognizant that any information provided by the OMS team to the patient’s attendant/family may be misunderstood or misconstrued. In addition, conversations between the surgeon and members of the OMS team in the presence of third parties may be admissible in subsequent investigations/litigation. The surgeon and the OMS team should maintain a level of professionalism including empathy for the patient’s condition and that of their friends and family. The OMS team discussion should not use terms of legal art including, but not limited, to negligence, liability, lawsuit, guilty, standard of care, medical error, mistake, and so forth.

**REPORTING AN UAE TO THE PROFESSIONAL LIABILITY INSURANCE CARRIER**

As soon as possible/practicable, the surgeon must report the UAE as an incident to their professional liability (PL) insurance carrier. The surgeon may report through an insurance agent or directly to their PL carrier. The sooner the incident is reported to the PL insurance carrier, the sooner the carrier will assign an attorney to the insured, if warranted.

The importance of timely reporting to the PL carrier is reiterated because these companies employ professionals who understand health care misadventures and can provide counsel concerning the specific mechanisms of action necessary. In addition, if the insured surgeon fails to report an incident that may provide the basis of a claim to their PL carrier within a reasonable time, this could potentially adversely affect the professional insurance coverage for that event. On balance, it is always prudent to report an incident that does not result in a claim rather than risk late reporting of an incident that does become a claim, thereby delaying the preparation of a defense strategy.

**APPOINTMENT OF DEFENSE COUNSEL AND THE POST-UAE PROCEDURE**

The assigned PL defense attorney (Defense Counsel) will assist with communication to the patient/family, the development of a strategy if litigation or regulatory action is forthcoming, reporting the UAE/adverse medical event to regulatory agencies, and in the drafting of narrative summary documents by the OMS team.

After Defense Counsel is appointed, they will confer with the OMS team as soon as possible to conduct interviews. A detailed narrative summary by the surgeon and each member of the OMS team is drafted using objective assessments of all facts and circumstances. The only subjective assessment should include statements made by the patient, the patient’s family, and so forth. All narrative summaries should state “attorney client privilege” and “work product privilege.” The narrative summaries of the OMS team members should be kept in a file separate from the clinical documentation. The file should be entitled: Litigation File “Patient Name” (Litigation File).

The clinical documentation of the patient encounter and any associated anesthesia records/report, vital signs recording data, and so forth, must be legible, complete, and correct. The documentation should be rechecked to make certain that the information included in the clinical record is comprehensive and contemporaneous. The clinical documentation and Litigation File should be sequestered from other patients’ clinical documentation and placed separately in a fireproof waterproof locked safe or metal filing cabinet.

In the event of an UAE or medical misadventure, the operatory/surgical suite must remain as it was left when the EMS transported the patient to the hospital ED. Photographs of the operatory/surgical suite should be taken to ensure that no corruption of the suite has occurred. Records should not be disposed of and any vials of anesthesia/sedation agents must be maintained in a sealed hard plastic container or in a plastic bag. Clinical operators can be cleaned, but information must be maintained and safely stored. Equipment must be sequestered to allow inspection if there are allegations of product liability/equipment malfunction in any subsequent negligence litigation.

The surgeon and any other personnel involved with the patient’s treatment must document all relevant information after the occurrence of the
UAE. The OMS team should never change or delete any existing entries in the clinical record. If needed, an amendment note should be written with careful explanation of why an amendment is necessary, particularly explaining the professional judgment involved. The team should state the facts as they are known and make no judgments concerning cause or responsibility. The same guidelines hold true for the filing of the incident report to the state regulatory agencies, which should be drafted within the requisite time period.

All discussions with the patient or family should be carefully documented in the clinical record. Although opinions may vary by jurisdiction, it is strongly suggested that the OMS team make their own set of complete personal notes, including personal opinions and observations about treatment, as soon as possible after the event. These will be extremely valuable 2 to 5 years later if necessary when preparing for testimony. It is critical that these personal notes are immediately given, as they are written, to the practitioners’ attorneys, marking them “attorney client privilege”/“work product privilege” and thus preventing later discovery of the notes by anyone else.

Another potential duty of the Defense Counsel is scheduling of grief counseling for the OMS team. There is a discussion later on the effect that cataclysmic patient injuries/death resulting from a UAE can have on the OMS team, both professionally and personally.

REPORTING THE UAE TO STATE REGULATORY AGENCIES

Most states have specific requirements within their Dental Practice Act or Department of Health to report adverse anesthesia occurrences or similarly termed events to state regulatory agencies. The OMS practitioner and team must be aware of the specific requirement to report adverse anesthesia occurrences and must be familiar with the specific requirements in the states in which they practice. Some states require the initial reports to be filed within 48 hours and may require a specific delivery requirement (eg, registered mail). The Board of Dentistry/Board of Medicine governing rules outline the information that needs to be provided.

Many states also require an additional report containing more comprehensive information. Incidents that may be required to be reported are those that result in temporary, permanent, physical or mental injury requiring hospital emergency room treatment and hospitalization of a patient during, or as a result of the use of general anesthesia, deep sedation, conscious sedation, pediatric conscious sedation, oral sedation, nitrous oxide, or local anesthesia during or relating to a dental procedure. Many states require that the report includes, at a minimum, responses to the following:

- A description of the dental procedure
- A description of the preoperative physical condition of the patient
- A list of the drugs and doses administered
- A description and detail of techniques of the drugs used
- A description of adverse occurrence including not limited to
  1. Description in detail of any complication to include but not limited to the onset of any symptoms in the patient
  2. The treatment instituted on the patient
  3. Response of the patient to the treatment
- The condition of the patient and termination of any procedure undertaken

In addition, if the surgeon has a double degree, DDS/DMD and MD or Doctor of Osteopathic Medicine, then they must report an adverse anesthesia occurrence to all regulatory boards under which they are presently licensed. Boards of Dentistry, Medicine, Osteopathic Medicine, and so forth may have requirements to report all outpatient medical misadventures (adverse incident reports) that do not involve the administration of local or other types of anesthesia. Again, it is imperative that the practitioner be aware of the reporting requirements in the jurisdictions within which they practice. Failure to report in a timely manner could be construed to be a violation of the Dental Practice Act or Medical Practice Act and could become probable cause for the OMS practitioner to be sanctioned by regulatory agencies, including fines, restriction of practice, mandatory continuing education, loss of anesthesia certification, suspension, or revocation of their dental/medical license.

OMS VISITATION AT THE HOSPITAL OR SERVICES

The surgeon should remain at the ED after the UAE until the patient stabilizes or a final decision is made concerning the patients’ condition. The more difficult decision is whether the surgeon should visit the hospital afterward if the patient remains admitted or, in the event of death, should the surgeon attend funeral services. There is no bright line rule as to the correct decision.

The surgeon must be cognizant of the dynamics of an encounter with the family of a patient who has been admitted to a hospital as a result of a UAE. The family may not have a sufficient knowledge base to understand the reason why their
family member has been hospitalized and the surgeon must realize that the environment in the hospital will be emotionally charged. Similarly, the funeral services of a patient who succumbed after a UAE could be emotionally volatile.

We advise the surgeon to contact the patient/family to inform them of their intention to visit/attend and to request their permission before their attendance at the hospital and/or services. Expressions of sympathy are appropriate as are the provision of flowers or donations to designated charities. Discussion with the patient’s family/friends using terms of legal art including liability, negligence, medical error, and so forth should be avoided.

MEDIA, PROFESSIONAL, AND PATIENT INQUIRIES

The OMS team must be aware of the potential for information inquiries after a cataclysmic UAE. The OMS team should be instructed to not speak to any person except their assigned Defense Counsel concerning the facts and circumstances surrounding the UAE. This includes refraining from any discussion of the UAE with their personal family members, friends, patients, practitioners, or amongst team members themselves.

In this the era of social media, the OMS team must be cognizant that information (and misinformation) spreads quickly and may be dispersed via all types of social media platforms (Facebook, texting, Twitter, iVideo/audio from smart phones) and can be uploaded onto the World Wide Web. If the OMS office has a Facebook page, they should not respond to inquiries concerning a UAE.

During any media inquiry, the OMS team must be aware that they may be video/audio taped and should be careful when speaking with people they cannot identify on the telephone. In addition, they should be careful about speaking on cellular phones where third parties can overhear their conversation. Information maintained on computers, smart phones, and so forth, must be password protected and the password should not be shared with others.

After a UAE involving a cataclysmic outcome, the OMS office will likely receive inquiries from fellow health care practitioners concerning the specifics of the event. Some of these inquiries may come from colleagues seeking information and offering assistance, but others may be inquiries from OMS referral base practitioners. The OMS team must be aware that the provision of information involving protected health care information to a third party without the proper patient authorization would be a violation of the Healthcare Insurance Portability and Accountability Act (HIPAA). Similarly, patients may make inquiries. Again the provisions of HIPAA apply and a practitioner disclosing protected health care information without the appropriate authorizations can be subject to sanction. No specific patient information or information concerning regulatory investigation/potential litigation can be provided without the patient/family’s written authorization or a subpoena from an official regulatory/judicial authority.

In the event of conventional media inquiry concerning a UAE, it is suggested that the OMS team speak with only 1 voice; preferably their Defense Counsel.

SHOULD THE ORAL MAXILLOFACIAL SURGEON RETAIN A PERSONAL COUNSEL?

As the surgeon may be aware, the Defense Attorney retained by their PL insurance carrier has a fiduciary duty to the surgeon, but their defense fees are paid by the insurance company. In cases where cataclysmic patient injuries/death occurs, there may exist potential for personal financial exposure to the surgeon above and beyond the indemnity limits of their insurance policy. Therefore, circumstances may arise when it would be prudent for the surgeon to retain a personal attorney to advise them and protect their personal interests if issues arise whereby their insured interests may not coincide with those of the PL insurance company. Each UAE would have to be assessed based on the specific facts and circumstances as to whether the retention of a personal attorney is warranted.

In some jurisdictions, the death of a patient at an ambulatory surgery facility can be investigated by the local authorities as a potential criminal event. The surgeon must be cognizant of the fact that, depending on the facts and circumstances of the specific UAE, although unlikely, they could be investigated for criminal prosecution. If that is the case, the surgeon must retain a personal criminal defense attorney to protect their interests.

WHEN IS AN APOLOGY TO A PATIENT AND/OR THEIR FAMILY APPROPRIATE?

There is much disagreement surrounding the discussion of when an apology is not an admission of liability, but rather an act of humanity. Multiple studies have demonstrated that patients clearly want errors disclosed and that they desire that clinicians apologize for their errors. However, clinicians frequently cite fear of malpractice lawsuits as a reason to avoid apologizing for an error.
Many states have enacted apology statutes, which have allowed patients, next of kin, and practitioners to engage in discussions when the adverse outcome may have warranted an apology and when appropriate. Current states with apology statutes are listed in Table 1.

We strongly suggest that the surgeon consults their counsel/personal Defense Counsel before engaging in an apology discussion. Clearly, a poorly crafted apology can constitute an admission against the practitioner’s interest. However, others have found that the act of apologizing with no admission of negligence or liability is an act of humanity that restores all parties.13

One health care practitioner and author has proffered that medical concepts of mistakes,
errors, and bad results require medical judgments, whereas the legal concepts of fault, negligence, and culpability are defined by legal standards. Injured patients are willing to forgive if the clinician is upfront with them. Medical mistakes do not trigger most malpractice suits; they result from patient/family anger about being spurned by caregivers after something goes wrong. Most malpractice claims arise from communication breakdown and full disclosure not only improves the litigation climate but also encourages better safety practices. The acceptance of full disclosure rests primarily with health care practitioners and to a much lesser degree with lawyers and legislators.14

In common law, an apology that includes an admission of negligence/fault may be admissible as evidence to support the liability of the defendant health care practitioner’s liability. All statements made in the course of informal settlement negotiations, including apologies, can be admitted into evidence. Statements made in the course of court ordered settlement negotiations such as at mediation are confidential and not discoverable. Therefore, an apology may be admissible as evidence at trial, and an apology that is entered into evidence is considered to be an admission by the defendant health care practitioner.

There are exceptions to the common law rule. First, apologies framed as hypothetical are not admissible; second, apologies that are preceded by exclusionary language such as “without prejudice to any of his legal rights, defendant admits...” are also inadmissible.

Based on an apology, the patient may file a complaint with the state Board of Dentistry, Board of Medicine, or Department of Health, which would result in an investigation. The apology may tempt a trial attorney to advise the patient to file a Department of Health complaint. Because the states' health care regulatory agencies are governed by consumer protection legislation, each complaint (even if anonymous) against a licensed health care practitioner must be investigated and likely will involve the subpoenaing of clinical documentation and review by an expert for the state. Therefore, if the state’s investigation yields a decision of probable cause and an administrative complaint is filed against the licensee, the investigative file becomes public record. The state will have conducted an investigation with an expert opinion report that would be discoverable and admissible in subsequent medical malpractice litigation. Effectively, the state will have funded discovery of a claim and the assertion of negligent care, using tax dollars, from which the patient may file medical malpractice litigation with little or no cost to the patient or their attorney.

If the oral maxillofacial surgeon practices in 1 of the 34 states and the District of Columbia that have enacted apology statutes, the surgeon must consider several questions when investigating their apology statute.

1. Is a statement of fault admissible?
2. Whose statements are protected?
3. To whom is the apology to be made?
4. Is the apology protected if oral and written?
5. Is an offer of additional assistance to a patient discoverable? (Clearly, medical bills should be dismissed.)
6. Is there a time limit by which a health care practitioner must proffer an apology to remain protected?15

Several investigators have questioned whether apologies have any impact on potential medical malpractice litigation. A recent study released from the University of Michigan reported on its comprehensive program to use apologies and offer financial compensation upfront after an unanticipated outcome. According to a 2009 article in the Journal of Health and Life Science Law, malpractice claims against the University of Michigan Health System fell from 121 claims in 2001 to 61 claims in 2006.

Curt and dismissive comments from an oral maxillofacial surgeon or defensive posturing will not be productive. Patients and families do request an immediate unbiased investigation with complete disclosure, a nonpatronizing demeanor, practices and systems changed to prevent a similar event, standards of care mandated with regulatory systems in place and a leader in charge, and justice.

Several investigators have queried whether the health care community can characterize and address the human dimensions of medical error so that patients, families, and clinicians may reach some degree of closure and move toward forgiveness?16 Clearly, much work remains to be performed in this area.

THE SECOND VICTIM

Mistakes and errors happen in most spheres of human life and activity, including medicine. When things go wrong during a health care encounter resulting in cataclysmic patient injury or death, there are often 2 victims; the patient who is harmed and the health care practitioner involved in the care.17 Dr Wu coined the term “second victim” in 2000 stating that “many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of
medical mistakes, doctors are wounded by the same errors: they are the second victims. Second victims often feel personally responsible for the patient outcome and feel as though they failed the patient. They often second guess their clinical skills and knowledge base.

The deleterious effect that a cataclysmic patient injury/death may have on the OMS team should not be diminished. Care should be taken with the decision on whether the OMS team believe they can return to administering patient care the same day as the UAE or even the next day. Grief counseling may ameliorate the immediate effect but there may be lingering consequences for months or years, evolving into to posttraumatic stress disorder. Scott and colleagues described the natural history of recovery for the second victim after a UAE. After interviewing 31 second victim health care providers, a predictable pattern of postevent trajectory of recovery consisting of 6 stages was identified. These are summarized in Table 2.

The sixth stage seemed to be the most critical in determining the ultimate fate of the health care provider. What is of preeminent importance is that the OMS team must be secure and continue on with their professional and personal life.

A health care practitioner and a patient have developed a new program for providing trauma support services to people who have experienced unanticipated outcomes from medical care or, more particularly, the failure of medical care. Medically Induced Trauma Support Services or MITSS (http://www.mitss.org) was developed in partnership by a patient and an anesthesiologist involved in an unanticipated event that seriously harmed the patient.

The emotional toll of medical error is high for both patients and clinicians, who are often unsure with whom and whether they can discuss what happened. Although institutions are increasingly adopting full disclosure policies, trainees frequently do not disclose mistakes, and faculty health care practitioners are underprepared to teach communication skills related to disclosure and apology. Several health care practitioners have developed an interactive educational program for trainees and faculty health care practitioners that assesses experiences, attitudes, and perceptions about error, explores the human impact of error through filmed patient and family narratives, develops communication skills, and offers a strategy to facilitate bedside disclosures.

Between spring 2007 and fall 2008, 154 trainees (medical students/residents) and 75 medical educators completed the program. Among the learners surveyed, 62% of trainees and 88% of faculty physicians reported making medical mistakes. Of those, 62% and 78%, respectively, reported that they did not apologize. Thirty-five percent of trainees said they would turn to senior doctors for assistance after an error, but 26% were not sure where to get help. Just 20% of trainees and 21% of physicians reported adequate training to respond to error.

An emotional response was reported in 82.4% of reports. Of those reports in which an emotional response was reported, a coping strategy was reported in 62.8%. The top 4 reported emotional responses were frustration (48.3%), embarrassment (31.5%), anger (12.6%), and guilt (10.1%). Physicians reported an emotional response more often than clinic staff. An emotional response was reported more often when there was a possibility of harm. Coping strategies were reported as follows: 52% talked to someone about the incident, 37.2% did nothing in response to the incident, 17.9% told the patient about the incident, and 3.6% did something else. Female physicians reported using coping strategies less often than male physicians. A coping strategy was reported more often when there was a possibility of harm.

Individuals who choose to become health care professionals are likely to be exposed to emotional turmoil repeatedly during their careers. It is normal for clinical members of health care teams to face unfortunate events with their patients. Entire health care teams can suffer when unanticipated clinical events or medical errors occur. Patient suffering from complications of treatment or consequences of medical mistakes can shake the strongest clinical foundation of seasoned health care providers, even jolting their career paths.

There is a profound irony here for health care delivery systems adopting strategies of continuous quality improvement (CQI). The reality is that although the fear of legal liability/repercussions prevents open discussion concerning mistakes, it is only through disclosure and opening of attitudes that the causes of mistakes can be identified, systems can be improved, future mistakes minimized and/or prevented, and attitudes toward medical misadventures can be modified.

Disclosure is 1 component of coping strategies developed for the second victim. These strategies are summarized in Table 3.

Effective disclosure can improve doctor and patient relations, facilitate better understanding of systems, and potentially decrease medical malpractice costs. However, many health care practitioners remain wary of discussing errors with patients because of concern about litigation, the communication challenges of disclosure, and loss of self-esteem.
Unfortunately, providers are often reluctant to discuss these emotions with colleagues and may not seek support from others as they cope with these emotions. Recent evidence shows that health care practitioners are dissatisfied with the emotional support they receive from health care institutions after medical errors. Multiple barriers present challenges for health care leaders in designing effective support programs, including physician perceptions of efficacy, privacy, and...

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<tr>
<th>Stages</th>
<th>Stage Characteristics</th>
<th>Common Questions</th>
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<tbody>
<tr>
<td>Stage 1 Chaos and accident response</td>
<td>Error realized/event recognized Tell someone → get help Stabilize/treat patient May not be able to continue care of patient Distracted</td>
<td>How did that happen? Why did that happen?</td>
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<tr>
<td>Stage 2 Intrusive reflections</td>
<td>Reevaluate scenario Self isolate Hauntedreenactments of event Feelings of internal inadequacy</td>
<td>What did I miss? Could this have been prevented?</td>
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<tr>
<td>Stage 3 Restoring personal integrity</td>
<td>Acceptance among work/social structure Managing gossip/grapevine Fear is prevalent</td>
<td>What will others think? How much trouble am I in? How come I can’t concentrate?</td>
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<td>Stage 4 Enduring the inquisition</td>
<td>Realization of level of seriousness Reiterate case scenario Respond to multiple why’s about the event Interact with many different event responders Understanding event disclosure to patient/family Physical and psychological symptoms</td>
<td>How do I document? What happens next? Who can I talk to? Will I lose my job/license? How much trouble am I in?</td>
</tr>
<tr>
<td>Stage 5 Obtaining emotional first aid</td>
<td>Seek personal/professional support Getting/receiving help/support Litigation concerns emerge</td>
<td>Why did I respond in this manner? What is wrong with me? Do I need help? Where can I turn for help?</td>
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<tr>
<td>Stage 6 Moving on (1 of the 3 trajectories chosen)</td>
<td>Dropping out Transfer to a different unit or facility Consider quitting Feelings of inadequacy Surviving Coping, but still have intrusive thoughts Persistent sadness, trying to learn from event Thriving Maintain life/work balance Gain insight/perspective Does not base practice/work on 1 event Advocates for patient safety initiatives</td>
<td>Is this the profession I should be in? Can I handle this kind of work? How could I have prevented this from happening? Why do I still feel so badly/guilty? What can I do to improve our patient safety? What can I learn from this? What can I do to make it better?</td>
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Adapted from Scott SD, Hirschinger LE, Cox KR. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. Qual Saf Health Care 2009;18:329; with permission.
availability. However, a few malpractice insurers and large medical centers have created programs that successfully provide emotional support to providers after errors through one-on-one counseling.27

MAINTAINING YOUR PRACTICE

As the demand for ambulatory OMS and anesthesia has increased, the incidence of UAE resulting in a cataclysmic result has also increased. The media have seized on the opportunity to increase the profile of these anesthesia misadventures in ambulatory health care.28

These events can and do occur in the absence of a violation of the standard of care, and their occurrence should not provide an inference that the practitioner was negligent. If an investigation of the UAE determines that the OMS team/practice requires remediation; this must be done. If an investigation involves litigation/lawsuits, those will be handled by the PL insurance carrier, the Defense Attorney, and possibly the personal attorney. The standard of care in medicine is not perfection. The most important necessity is for the OMS team to develop the ability to continue with their professional and personal lives.

REFERENCES


Table 3

<table>
<thead>
<tr>
<th>Coping with mistakes and errors in judgment</th>
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<tbody>
<tr>
<td>1. Accept responsibility for the mistake</td>
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<tr>
<td>2. Discuss with colleagues</td>
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<td>3. Disclose and apologize to the patient</td>
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<td>4. Conduct an error analysis</td>
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<tr>
<td>5. Make changes in practice or practice setting designed to reduce future errors</td>
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<tr>
<td>6. Work at local and national levels to change the culture of the medical profession with regard to the management of medical mistakes</td>
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