Correspondence

Malpractice—Fifteen Years Later

To the Editor:—The HEW Secretary's Commission on malpractice determined that Anesthesiology and Orthopedic Surgery "by the very nature of the high risk procedures they undertake, are subject to claims more frequently. . . ."[1] If true, anesthesiologists must take positive action to reduce their exposure. In 1957 I commented on the malpractice problem and pointed out the seriousness of the situation, which has increased since.[2]

It is still my experience after 25 years of reviewing instances of alleged malpractice relating to the administration of anesthesia that reasons for the allegations are mainly: 1) No patient contact by the anesthesiologist. 2) Preoperative orders were frequently by telephone. 3) Any written preanesthetic evaluation was cursory or not found. 4) Anesthetic record was incomplete or illegible. The anesthesiologist could not decipher his own record at a deposition taken a year or more later. 5) No written record describing the accident, reasons, or treatment. 6) No postanesthetic record indicating, at least, some concern over the event.

This lack of documentation makes the anesthesiologist a prime target for any plaintiff's attorney, even though the incident for which the plaintiff is demanding financial remuneration may have been only partially or not at all related to the anesthetic. The anesthesiologist stands out as the sole target as clearly as the sun over a desert at noon in all instances of cardiac arrest with death or, even worse, with consequent permanent brain damage.

One hope for lessening exposure is the development and uniform use of a problem-oriented anesthetic record. A second is an honest weekly review of all untoward events for the purpose of upgrading the quality of anesthetic care and records as true peer review. A third method, which we introduced in this department during the past year, is the insistence that whenever any untoward event occurs during or after an anesthetic, a complete description of the patient and the event be *dictated immediately*, with details of everything done, reasons and explanations. A copy of this record is placed in the patient's record, a copy is sent to the Hospital Administrator and the anesthesiologist retains a copy.

The dictating system used is the same one used by the surgeon in dictating his operative report, which sometimes innocently infers responsibility which did not exist. This dictated report is a simple device which provides some protection, if not in avoiding claims, at least in reducing the consequences of such claims, justified or not.

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REFERENCES

1. Medical Malpractice. Report of the Secretary's Commission on Medical Malpractice. DHEW Publ. No. (05) 73-88, June 1973, p 8
2. Dillon J: The prevention of claims for malpractice. ANESTHESIOLOGY 18:794-96, 1957

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Estimation of Inspiratory-limb Humidity in the Circle System

To the Editor:—In their comprehensive studies to predict whether inspiratory gases will reach the recommended humidity zone ("Humidity output of the circle absorber system," ANESTHESIOLOGY 38:458–465, 1973), Dr. Chalon and his colleagues have constructed nomograms which require estimation of carbon dioxide production. This