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The Needle and the Damage Done: Anesthesia Workplace Addiction

Defending the Addicted Anesthesiologist

Opioid addiction remains a significant issue in the anesthesia workplace. While anesthesiologists may suffer from addiction to alcohol and other substances, the drug of choice for most anesthesiologists entering treatment programs continues to be opioids.

Addiction to opioids and other substances puts patient safety at risk and devastates anesthesiologists' lives, families and professional careers. From a professional liability perspective, allegations that an anesthesiologist was under the influence of narcotics or other substances while rendering care and treatment to a patient significantly increases liability exposure to both the individual anesthesiologist and the anesthesia practice group.

It is also important to note that nearly all professional liability insurance policies, including PPM's, exclude coverage for liability arising from substance abuse.[1] While mere allegations of substance abuse do not typically result in a denial of coverage, insurance carriers must make a case-by-case determination based on the specific allegations, facts and evidence. Making misrepresentations or false statements regarding substance abuse on an insurance application or recertification statement may also jeopardize the individual PPM policyholder's insurance coverage.

If allegations of substance abuse are ultimately proven in a medical negligence lawsuit, the addicted anesthesiologist may be faced with no insurance coverage resulting in their personal assets being exposed to any judgment from a lawsuit. Further, the addicted anesthesiologist may be faced with personally paying the considerable costs of defending a lawsuit.

Additionally, allegations of substance abuse often result in punitive or exemplary damage claims. Punitive or exemplary damages arise when the defendant's acts are determined to have been intentional, willful, malicious, wanton, fraudulent, or criminal. Nearly all professional liability insurance policies, including PPM's, also exclude coverage for liability arising from punitive or exemplary damage claims.[2]

Anesthesia practice groups that employ an addicted anesthesiologist may also face significantly increased liability exposure in the event of a lawsuit with allegations of substance abuse. In addition to the possibility the individual addicted anesthesiologist may not have insurance coverage, the anesthesia practice group's corporate assets may be at risk due to punitive or exemplary damage claims.

Defending Substance Abuse in the Courtroom

While PPM's strict underwriting policies and guidelines have avoided most situations involving allegations of substance abuse against PPM policyholders, there have been a few cases in which PPM was faced with this difficult challenge. Lawsuits previously evaluated as defensible often become impossible to defend when evidence of substance abuse is admitted. In those rare cases, PPM has typically been forced to settle lawsuits it would otherwise defend through trial.

"Plaintiff attorneys dream of representing clients in medical negligence cases in which there is evidence of substance abuse by a physician or other healthcare provider," according to Wade Willard, Claims Supervisor. "Even the slightest evidence that a physician or healthcare provider was a substance abuser or under the influence during the procedure is often enough to anger juries and influence them to award huge sums of money to the plaintiff. Faced with the significant threat of a jury verdict that might exceed the available insurance policy limits, PPM's ability to defend an addicted anesthesiologist becomes extremely difficult and costly," added Willard.

Further, PPM's experience has been that courts are frequently willing to allow plaintiffs to present evidence of substance abuse at trial. Even when the evidence of abuse may have occurred years before or after the procedure in question or stems from confidential and privileged communications between the anesthesia provider and a counselor, psychologist or physician, courts have allowed plaintiffs to present this damaging evidence to juries.

However, as illustrated by the case below, even when courts have allowed plaintiffs to present evidence of substance abuse to a jury, PPM has been able to successfully defend PPM's policyholders. Other cases have resulted in significant settlements driven by substance abuse allegations and the threat of run-away jury verdicts.

- A 42 year-old male underwent a bilateral inguinal hernia repair under general anesthesia. Arms were positioned and padded by a PPM insured CRNA and a circulating nurse. Post-operatively, the patient complained of right shoulder pain. The patient sued the supervising PPM insured anesthesiologist, CRNA and anesthesia group. Plaintiff also sued the surgeon and the hospital. The plaintiff alleged improper positioning resulted in a brachial plexus injury. Hospital charts and subsequent treatment were not consistent with the diagnosis of right shoulder pain. Qualified experts who fully supported the PPM insured policyholders' care were retained and the case was prepared for trial.

  Five years after the procedure in question and during the pendency of this lawsuit, the CRNA was caught abusing fentanyl. The anesthesia group terminated the CRNA's employment, his nursing license was suspended, and he entered a drug treatment program. During the CRNA's deposition, he testified he was not abusing fentanyl at the time of the procedure in question. No other witnesses testified that the CRNA exhibited any behavior that would suggest he was under the influence during the time period surrounding the procedure. Plaintiff's counsel subpoenaed the CRNA's employment and drug treatment records in an attempt to show the CRNA was abusing narcotics during the time of the procedure.

  Plaintiff amended his complaint to include allegations of negligent hiring and supervision against the anesthesia group. Due to the conflicts that arose as a result of the CRNA's substance abuse, PPM retained separate defense counsel on behalf of all three PPM policyholders. Over defense counsel's objection, the court ordered the CRNA to disclose his confidential and privileged communications with his treating psychologist and drug counselor.

  Plaintiff's last settlement demand prior to trial was $5 million. With the consent of all PPM policyholders, PPM offered $150,000. Plaintiff rejected PPM's settlement offer and we proceeded to trial.

  During trial, over defense counsels' objections, the court allowed the plaintiff's attorney to introduce evidence of the CRNA's subsequent fentanyl abuse. Despite the fact there was absolutely no evidence to support plaintiff's allegation of substance abuse during the time period surrounding the procedure date, the court allowed plaintiff's counsel to argue to the jury that the CRNA was under the influence of narcotics during the procedure in question. Defense experts retained on behalf of the PPM insured policyholders testified there was no evidence the CRNA was abusing fentanyl during the procedure. Defense experts testified further that the PPM policyholders met the standard of care and this type of injury can and does occur absent negligence on behalf of any healthcare provider.

  Following a two week jury trial, the jury returned a unanimous defense verdict on behalf of all PPM policyholders and the other defendants. Plaintiff appealed the jury verdict and nearly two years later the appellate court upheld the unanimous defense verdict. PPM paid a total of $676,633 defending this case.

- A 53 year-old male underwent a cervical disk fusion with instrumentation. During the procedure the surgeon punctured the vertebral artery. When the PPM insured anesthesiologist was informed of the complication he ordered typed and crossed blood. After a significant delay, the PPM insured anesthesiologist ordered uncrossed blood which took another hour to receive. During this time the patient lost about 2000 ccs of blood and hematocrit was noted to be low. Due to a delay by the hospital, the blood was transfused nearly four hours after it was ordered. In the recovery room the patient did not fully regain consciousness. The patient was transferred to another facility and admitted to its ICU. Later the patient was noted to have increased intracranial pressure and a bleeding intracranial colloid cyst. The patient eventually experienced respiratory arrest and expired.

  The patient's wife sued the PPM insured anesthesiologist, the anesthesia practice group and the hospital. The plaintiff alleged the PPM insured anesthesiologist fell below the standard of care by failing to

adequately treat decedent's significant blood loss to prevent hypoxic/anoxic brain injury resulting in death. Plaintiff's allegations against the PPM insured anesthesia group were for vicarious liability based on the alleged negligence of the PPM insured anesthesiologist. The plaintiff alleged the hospital was negligent for not having blood and blood products readily available and the significant delay in obtaining blood for this procedure.

Qualified defense experts who supported the PPM insured anesthesiologist's care and treatment were retained. During discovery, the PPM insured anesthesiologist disclosed to defense counsel that he was addicted to narcotics. The PPM insured anesthesiologist self-reported to the licensing board, had his medical license suspended, resigned from the anesthesia practice group and PPM canceled his insurance policy.

During the PPM insured anesthesiologist's deposition, plaintiff's attorney asked several questions regarding his narcotic addiction. Upon advice of his counsel, the PPM insured anesthesiologist refused to answer those questions. Plaintiff's attorney filed a motion to compel the PPM insured anesthesiologist to answer the questions regarding his narcotic addiction.

Prior to the court's ruling on plaintiff's motion to compel and upon advice of defense counsel, PPM participated in a settlement conference with plaintiffs and the hospital. Based on the inflammatory allegations of narcotics abuse and defense counsel's evaluation that the court would allow evidence of substance abuse to be admitted at trial, PPM settled this case for $1.5 million on behalf of both PPM policyholders. The hospital reached a confidential settlement with plaintiffs.

Identifying the Addicted Anesthesiologist

As recently as 2005, the drug of choice for anesthesiologists entering treatment programs was an opioid, with fentanyl and sufentanil topping the list.[3] Other agents, such as propofol, ketamine, sodium thiopental and lidocaine are less frequently abused but have documented abuse potential.[4] Alcoholism and other forms of impairment affect anesthesiologists at similar rates to those in other professions.[5] Proximity to large quantities of highly addictive drugs, the relative ease of diverting small quantities of these agents, the high-stress environment in which anesthesiologists work, and exposure in the workplace are all factors that have been proposed to explain the relatively high incidence of drug abuse among anesthesiologists.

Changes in an addicted anesthesiologist's behavior are frequently noted. Therefore it is imperative that those people most likely to observe the signs and symptoms of addiction – i.e., the relatives, friends and co-workers – understand the disease and what to do if they suspect a colleague may have a problem. Early identification can prevent harm to patients and the addicted anesthesiologist.[6]

Some of the changes typically observed in the addicted anesthesiologist include, but are not limited to:[7]

- Mood swings with periods of depression alternating with periods of euphoria
- Increased episodes of anger, irritability, and hostility
- Spending more time at the hospital, even when off duty
- Volunteering for extra call
- Refusing relief for lunch or breaks
- Requesting frequent restroom breaks
- Signing out increasing amounts of narcotics or quantities inappropriate for the given case
- Weight loss and pale skin

Other behavior patterns include charting the use of an agent when in fact either an alternate agent or none at all was administered; substituting a syringe containing their drug of choice for one containing saline or tap water; always wearing long-sleeved shirts; rummaging through sharps containers looking for residual drugs in discarded syringes; and circumventing the security features of automated dispensing machines.[8]

Legal Issues

A number of legal issues arise when dealing with an addicted anesthesiologist. The anesthesiologist who is reported to either the state licensing board or a physician referral program faces several legal decisions. The reported anesthesiologist should consult with legal counsel because of the likelihood of suspension, and possible revocation, of his or her medical license. In addition to actions taken against licensure, state, local and federal authorities may institute criminal charges, including charges for diversion of controlled substances.[9]

Failure to report an impaired colleague may be considered negligence and expose the individual and/or entity that becomes aware of the impairment to liability if a patient is injured. It is important to note that the legal requirements and protections associated with physician impairment are different from state to state. Failure to report an impaired colleague as required by law may also result in disciplinary action against the individual and/or entity. Most state laws provide immunity for individuals who report an impaired professional. Each state has its own laws regarding mandatory reporting and immunity. Typically, the individual or entity reporting the impaired professional is immune from civil suit as long as the reporting is made in good-faith.[10] PPM policyholders are encouraged to consult with local counsel and PPM with regard to their particular state law governing reporting physician impairment and immunity.

Drug Testing

While still considered controversial, PPM encourages anesthesia practice groups to implement workplace drug testing policies as part of an effective risk management plan. Policies include pre-employment testing, suspicion-based testing, and random testing of employees.

Some forms of testing are more controversial than others, but all involve some form of intrusion into an individual's personal privacy. All forms of testing should balance the goal of patient safety against the reasonable expectation of privacy.[11]

Pre-employment testing is the least controversial drug testing policy, especially when conducted as part of a pre-employment physical examination. In reviewing the cases involving pre-employment testing, the courts' rationale has been that the job applicants have less of a vested interest in a position than do those already employed. If applicants do not want to be tested, they are free to seek employment elsewhere.[12]

Next to pre-employment testing, testing based on reasonable suspicion that an employee is impaired has been widely accepted and endorsed by the American Hospital Association and the American Medical Association.[13] Depending on state and federal law, hospitals and other entities may be required to drug test healthcare providers when alerted to suspicious behavior. As noted above, anesthesia practice groups may face liability exposure and separate allegations of negligence if the group becomes aware of suspicious behavior by one of its employees and does not have a drug testing policy in place. PPM encourages anesthesia practice groups to develop and implement their own drug testing policy.

Random testing of existing employees is the most controversial drug testing policy. Currently, statutes in twelve states prohibit random testing, but many of these statutes do not apply to testing of employees holding safety-sensitive jobs.[14] Absent constraints by statute, courts have uniformly upheld random testing when the employer established that positions involved were safety-sensitive.

Zero Tolerance vs Impaired Physician Policies

Two options are available for addressing anesthesia workplace substance abuse by employees: a zero-tolerance policy that results in immediate termination or an impaired physician policy that attempts to arrange for assessment, treatment and potential return to the practice of anesthesia.

The Drug Free Workplace Act of 1988[15] requires federal contractors to take specific measures to maintain a drug-free workplace. This federal law emphasizes drug testing not as a method of detection but deterrence. Many businesses that do not have a government contract have implemented the same policies – including pre-employment, reasonable suspicion, and random drug testing – to combat workplace substance abuse.

Under the zero-tolerance policies, violators do not receive a second chance and are immediately terminated. The rationale behind zero-tolerance policies is the threat of being terminated provides a potent deterrent to substance

abuse and will prompt some substance abusers to seek help for their addiction. Given the significant risk to patient safety and liability concerns posed by an impaired anesthesia provider, some anesthesia practice groups have implemented zero-tolerance policies.

Other anesthesia practice groups have implemented impaired physician policies designed to assist employees rather than requiring immediate termination. Impaired physician policies assist the impaired physician in getting into a treatment program, providing monitoring, random drug tests and continued counseling following successful completion of an inpatient treatment program.

Whether anesthesia providers should be allowed to return to the practice of anesthesia after successful treatment remains controversial. Due to the significant risk for relapse in addicted anesthesia providers, anesthesia practice groups should require a letter from the treating addiction physician who approves re-entry to the practice of anesthesia.

In cases where the treating addiction physician has approved the impaired anesthesia provider's re-entry to the practice of anesthesia, it is imperative that anesthesia practice groups require the impaired anesthesia provider to remain under the treatment and supervision of an addiction physician, monitor the impaired anesthesia provider typically for a minimum of five years, and conduct random drug testing.

PPM has a well-developed program for assisting PPM policyholders handling situations involving substance abuse. PPM policyholders are encouraged to contact PPM if substance abuse is identified in the anesthesia workplace.

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PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP, INC.
9000 West 67th Street
Shawnee Mission, KS 66202-3656

T 913.262.2585 • 800.562.5589
F 913.262.3633

NEWSLETTER EDITOR
Brian J. Thomas, JD
Senior Claims Attorney
Director of Risk Management

PPM

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In This Issue

Opioid addiction and the challenges of defending impaired anesthesia providers remain a significant issue in anesthesia. In this issue, we examine how addiction in the anesthesia workplace negatively impacts PPM's ability to defend lawsuits. We also highlight some of PPM's challenges in defending addicted anesthesia providers in the courtroom. Finally, we offer some risk management advice for implementing workplace substance abuse policies as an effective risk management plan.

Thanks for reading,

Brian J. Thomas, Editor