ASA

Australian Society of Anaesthetists

Catastrophes in Anaesthetic Practice

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SECTION 1 - SUMMARY

- Anaesthetists are likely to be involved with an anaesthetic catastrophe at some point in their careers.
- There may be significant psychological impact on staff.
- The clinical commitment of the anaesthetist concerned should be reviewed.
- A team approach should be adopted when breaking bad new to relatives.
- The task of breaking bad news should be carried out by a senior member of the anaesthetic department.
- All hospitals should have procedures in place for dealing with and investigating catastrophic events.
- Critical incident debriefing and psychological support may assist individuals to recover from the traumatic event.
- Contemporaneous records of the event must be kept.

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SECTION 2 – INTRODUCTION

Deaths due to anaesthesia are uncommon with an estimated incidence 1 in 56,000[1]. We are all likely to be associated with an intra-operative death at some point in our careers. Most are expected or understood. When death or serious injury is unexpected, the experience can be extremely traumatic for all concerned. The 2000-2002 Confidential Enquiry into Maternal and Child Health report recommended that anaesthetists and staff who were involved in a maternal death should receive supportive counselling[2].

Whether a death or serious adverse outcome is 'expected' or 'unexpected' may be irrelevant, as the anaesthetist involved may be emotionally affected. The training and ethos of anaesthesia to avoid harm and maintain patient safety at all times puts additional stress on the anaesthetist[3,4,5,6,7]. The psychological effects of an intra-operative death or serious injury on a background of continuing stress, may tip the balance towards acute personal, psychological or physical decompensation[8].

It is the responsibility of all hospitals to have governance and risk management systems in place to deal with a catastrophe.

It is incumbent on colleagues, hospital staff, hospital administration and family to provide practical help and support to the anaesthetist involved according to individual needs. This should be regarded as part of good clinical governance and risk management

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SECTION 3 – ACTIONS TO BE TAKEN AFTER THE EVENT

Consult departmental guidelines if available.

Immediate Actions

Records

- Keep an accurate and contemporaneous record of the anaesthetic and event.
- Electronically stored monitoring records should be printed and filed in the notes.
- Where practical, it is advisable during attempted resuscitation to allocate one member of the ream to record times, the personnel involved and interventions including details of all drugs, fluids used and outcomes.
- Original notes and charts must not be altered in any way at a later date. Amendments and additions must be recorded separately, timed, dated and signed.
- Any subsequent entries to the contemporaneous notes should be made in the same way.
- Details of the pre-operative discussions with the patient regarding the risks of anaesthesia and surgery should be documented.
- It is important to keep copies of the records and make personal notes as these may be required later.
- Contact your Medical Defence Organisation (MDO).

Dealing with the anaesthetist

For trainees/registrars, the responsible consultant should attend in person. A consultant anaesthetist should inform a colleague who should attend the hospital and assist with the aftermath. A decision will need to be made whether the anaesthetist should continue with his/her list or on-call. The decision is best made after assessing the situation with the anaesthetist involved, senior colleagues and the clinical director where appropriate.

Dealing with the patient

- In the event of a death, all appropriate documentation should be completed as soon as possible, including, where applicable forms for the relevant Death Under Anaesthesia Committee or equivalent.
- In the event of death, all lines, tubes and other equipment connected to the patient must be left in place. If there is any cause for concern regarding the placement of the endotracheal tube, the position should be confirmed and recorded by an independent anaesthetist.
- In the event of a medical catastrophe where the patient survived, it is important for the anaesthetist concerned to take an ongoing interest in the progress of the patient.
- The anaesthetist involved should contact his/her MDO. It is important to complete a critical or adverse incident form.

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Dealing with relatives

Breaking bad news should be done in person wherever possible. It may be necessary to invite the relatives to come to the hospital informing them that a serious complication has occurred but no details should be given. If there is no immediate family to accompany the relative, ask the relative to bring a friend. Some hospitals have established a pastoral service, which can be helpful for grieving relatives.

The interview with the family

This will consist of an initial interview, possibly followed by more depending on the situation. Find a suitable quiet and comfortable room free from interruption for the interview. Do not speak to the family on your own. A team approach is recommended.

Speak to the family with your surgical colleague who may already have encountered members of the family prior to the operation. Other team members could include theatre and chaplaincy staff or other support staff including an interpreter if appropriate.

Explain the ‘bad news’ first in a straightforward and honest way, followed by answering any questions which may arise. If the cause of the disaster is known, then this should be explained in lay language. Giving an apology does not imply fault. However, if no cause has been specified, **do not** speculate or offer an opinion. Take time, listen and empathise. Use an interpreter in cases where understanding of English is limited. Give the family the time to take in the bad news and do not give them too much information initially.

It may be necessary to conduct a second or subsequent interview after a relatively short period of time to give further information, answer questions or to clarify certain issues.

Subsequent Actions

Equipment and Drugs

The clinical director or a consultant not involved with the incident should take responsibility for checking the patient and equipment. If there is suspicion of equipment failure or a hazard affecting the theatre, a decision may be made to take the theatre or anaesthetic machine out of commission until further notice.

All anaesthetic equipment, drug syringes and ampoules should be kept, and moved to a secure storeroom for investigation. An accurate record should be made of all the checks undertaken including time and date of inspection. All disposable equipment including syringes and ampoules, airway devices etc. should be kept in a secure place. Further investigation may be required by medical equipment maintenance personnel, manufacturers or toxicologists.

Dealing with the theatre team

The team should be initially debriefed at a time to suit all staff and preferably within a few hours of the catastrophe. The aim is to provide and record information, and to gain feedback

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while details are still fresh. It is also useful to allay anxieties or misconceptions experienced by the members of the theatre team. The presence of a trained counsellor may be useful.

Dealing with the media

The media may try to approach staff at the hospital or at home. A nominated hospital representative should be the only person communicating with them. All media enquiries should be directed to this person. [9]

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SECTION 4 – THE ROLE OF THE DEPARTMENT OF ANAESTHESIA

It is vital that members of the anaesthetic department support the anaesthetist who may be stressed or traumatised[10]. A stressed anaesthetist will be more prone to making errors.

It is important to listen to the individual and encourage them to talk. Refrain from being judgmental. Informal, sympathetic peer review with colleagues is often useful. All conversations should be kept confidential. At a later date, when the cause of the catastrophe is known, a departmental mortality and morbidity meeting may be useful to inform and learn lessons from the incident.

A senior anaesthetic colleague should be assigned to act as mentor and provide support for as long as necessary. The mentor should be known and accepted by the anaesthetist concerned. Members of the department may have to take over the involved anaesthetist's duties including on call commitments, for a period of time.

The anaesthetist will feel particularly vulnerable when a catastrophe occurs in a private facility. It is the responsibility of the concerned anaesthetist to inform their colleagues of the catastrophe in order to obtain as much assistance as possible.

Department of anaesthesia in private hospitals should have these same systems in place, to help in the event of an anaesthetic catastrophe.

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SECTION 5 – THE HOSPITAL RESPONSE

The Clinical Director (CD) is responsible for the patient safety in anaesthesia. The CD should make an assessment of the nature of the incident to determine whether the catastrophe could recur or put other patients or staff at risk. A root – core analysis may be required.

Urgent actions:

- Secure the area or equipment until investigated.
- Identify and support all staff involved.
- Keep a record of all actions.
- Check that the relatives have been contacted and cared for.
- Ascertain if there is any evidence of an equipment or drug problem.
- Ascertain if there is any possibility of physical impairment.
- Ascertain if there is any evidence of poor staff performance or system failure.
- Contact the GP.
- Ensure that the incident forms have been completed.
- Together with the appropriate manager ensure that the relevant theatre staff are supported and have been debriefed.
- Arrange for statements to be made by all who were present during the incident. Statements should be descriptions of what happened rather than interpretations of events. Statements may be legally disclosed in the future, so accuracy and care is essential.
- Prevention of future incidents utilising a systems based approach for risk management.

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SECTION 6 – MEDICO-LEGAL ISSUES

Any professional involved in a medical catastrophe in their practice should assist in an investigation into what happened and why. While the prospect of medico-legal consequences will weigh heavily on the mind of any anaesthetist involved in a catastrophic outcome, it should be remembered that very few cases actually result in a formal disciplinary hearing or action for compensation.

The wheels of the medicolegal processes turn slowly and memory can become very inaccurate as time passes. The best defence for one's actions is a comprehensive, contemporaneous and accurate record of events. These should be stored in an appropriate location and may need to be kept for many years. Your MDO, mentor and department will be able to help you prepare for any medicolegal or disciplinary investigations.

State Licensing Boards

The various state medical boards require doctors in practice to take appropriate action if they are aware of concerns about another individual's ability to practice safely. This requirement extends to medical directors who may feel it appropriate or necessary to report an incident, which might indicate a problem with a doctor's competence or performance. The Medical Board will let the individuals know that they have received a complaint or comment about them and invite a response. Once again it is vital to inform one's medical defence organisation as early as possible.

Following initial investigation, case examiners may decide that no further action is warranted, issue a formal warning or refer the case to a panel for final adjudication[11]. The case examiners can also ask to consider temporary suspension from, or restrictions to, the doctor's practice while the investigation is underway. Once again, if this does eventually proceed to a formal hearing, the time delay can be very significant and the importance of good contemporaneous notes is vital.

The MDO's and Treasury Managed Funds (TMF) may provide doctors with legal representation for Medical Board hearings.

Civil Litigation

A possible outcome of an unexpected peri-operative death or serious injury is a civil case for negligence being brought against the hospital or the individual practitioner, or both. This is a slow process, with prolonged preliminary stages designed to minimise the number of cases coming to Court, and the involvement in supplying a witness statement. It is not unusual for civil cases to drag on for five years or more after the precipitating event. If it is a child who has suffered injury, the claim may not be made for many years.

There are a number of reasons why the TMF or MDO may decide that a civil suit should be **settled out** of court. It is often a frustrating experience for anaesthetists who are confident that they could defend their own actions in a public arena, but there may be other aspects of the case which cannot be defended.

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Should you be called to give evidence[12], it is essential to have good quality records and to spend as much time as necessary refreshing your memory of the facts of the case; it is very difficult to jog one's memory from a large bundle of case notes in the stressful environment of the witness box. It is advisable to go over the events of the case with a colleague and, if unfamiliar with the workings of the law, visit the court beforehand to get an idea of layout, behaviour and protocol. Try not to get flustered by cross-examination, answer politely, slowly and truthfully, addressing the Judge at all times, and do not be tempted into giving an expert opinion.

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SECTION 7- SOURCES OF HELP

Consult your medical defence organisation in the first instance.

Occupational Health Department

General Practitioner

All doctors should have a local GP. If you feel that the stress of your job, or of any particular incident at work, is affecting your health, you should make an appointment to see your GP. GP practices often have access to counselling services.

Phone based resources

Doctors Support Line

Confidential, anonymous telephone helpline for doctors with any concerns whether work related or not. Staffed by trained volunteer doctors.

Doctors Health Advisory Service

Confidential counselling service for discussing personal, emotional and work-related problems. Available 24 hours a day on the following numbers. www.doctorshealth.org.au

ACT: 02 6270 5410
NSW: 02 9437 6552
VIC: 03 9280 8722
TAS: 03 6223 2047
QLD: 07 3872 2222
SA: 08 8222 5501
WA: 08 9273 3000
NT: 08 8927 7004

Impaired Doctors Schemes

Which are run through State Medical Board's.

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Web based resources

Office of the Australian Safety and Compensation Council
www.ascc.gov.au

Therapeutic Goods Administration (TGA)
www.tga.gov.au

Medicines Australia
www.medicinesaustralia.com.au

Australian Commission on Safety & Quality in Healthcare (ACSQHC)*
www.safetyandquality.org
*was previously the Australian Council for Safety & Quality Healthcare

National Clinical Assessment Authority (NCAA)
National Health & Medical Research Council (NHMRC) - www.nhmrc.gov.au
Medical Services Advisory Committee (MSAC) - www.msac.gov.au

State Government Authorities
NSW: Healthcare Complaints Commission (HCCC)
www.hccc.nsw.gov.au

VIC: Health Services Commissioner
www.health.vic.gov.au/hsc

ACT: Australian Capital Territory Health Services Complaints Commissioner
www.healthcomplaints.act.gov.au/c/hcc

WA: Office of Health Review
www.healthreview.wa.gov.au

NT: Health & Community Health Services Complaints Commissioner
www.nt.gov.au/omb_hcscc/hcscc

QLD: Health Rights Commission
www.hrc.qld.gov.au

SA: SA Health Commission (SAHC)
www.hcscc.sa.gov.au/cgi-bin/wf.pl

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Medical Boards

Australian Medical Council

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New South Wales Medical Board

Street Address:	The Old Gladesville Hospital Grounds 2nd Gate Entrance (on left) Off Punt Road Gladesville NSW 2111
Mailing Address	PO Box 104 GLADESVILLE NSW 1675
Contact Details	Telephone: (02) 9879 2200 Facsimile: (02) 9816 5307 Email: mswmb@nswmb.org.au Web: www.nswmb.org.au

Victorian Medical Practitioners Board

Location	Level 16, 150 Lonsdale Street Melbourne VIC
Mailing Address	GPO Box 773 Melbourne VIC 3001
Contact Details	Telephone: 03 9655 0500 Facsimile: 03 9655 0580 Email: info@medicalboardvic.org.au Web: www.medicalboardvic.org.au
Registrations Department	Telephone: 03 9655 0555 Facsimile: 03 9655 0582 Email: registrations@medicalboardvic.org.au

Professional Conduct Department

Telephone: 03 9655 0560
Facsimile: 03 9655 0580
Email: conduct@medicalboardvic.org.au

Medical Council of Tasmania

Address:	306 Murray Street HOBART TAS 7000
Mailing Address:	The Registrar Medical Council of Tasmania PO Box 8 SOUTH HOBART TAS 7004
Contact Details	Phone: 03 6233 5499 Facsimile: 03 6233 7986 Email: mct@medicalcounciltas.com.au Web: www.medicalcounciltas.com.au

Medical Board of the Australian Capital Territory

Postal Address:	Medical Board of the ACT PO Box 976 CIVIC SQUARE ACT 2608
Location	197 London Circuit Level 6 Eclipse House CIVIC ACT 2608
Contact Details	Phone: 02 6205 1600 Facsimile: 02 605 1602 Email: medicalboard@medicalboard.act.gov.au Web: www.medicalboard.act.gov.au

Medical Board of the Northern Territory

Postal Address	PO Box 40596, CASURINA NT 0811
Location	Health House 87 Mitchell Street DARWIN NT
Contact Details	Telephone: 8999 2400 Facsimile: 8999 2700 Email: ask us online Web: www.nt.gov.au/health

Medical Board of Queensland

Location	Level 19 Forestry House 160 Mary Street Brisbane
Mailing Address	Medical Board of Queensland GPO Box 2438 BRISBANE QLD 4001
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Medical Board of Western Australia

Location	8th Floor, London House 216 St Georges Terrace PERTH WA 6001
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Medical Board of South Australia

Location	Medical Board of South Australia 91 Payneham Road St Peters 5069 South Australia
Mailing Address	Address all correspondence to the Registrar PO Box 359 Stepney 5069

	South Australia
Contact Details	Telephone: 08 8132 6444 Fax: 08 8362 7906 Email: admin@medicalboardsa.asn.au Web: www.medicalboardsa.asn.au

SECTION 8 – REFERENCES AND FURTHER READING

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