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Anesthesia related claims from 2014-2024

JEANNETTE DOMASK, MPH, CPHRM, OMIC Risk Manager

This analysis of anesthesia-related claims is a follow-up to a prior OMIC study from 2008-2018 that included 63 claims. Although there is a 4-year overlap in the study period, this does not have an impact on our conclusions. In this study we identified 49 anesthesia-related claims from 2014-2024.

We analyzed the frequency and severity (settlement or verdict values) of claims related to anesthesia providers in ocular surgery, which included anesthesia provided by ophthalmologists (OMD), anesthesiologists (AMD), or certified registered nurse anesthetists (CRNA). The data only reflects claims in which the OMIC insured ophthalmologist was a named defendant.

We often receive risk management inquiries about liability risks associated with using CRNAs versus AMDs. Due to AMD shortages and decreasing reimbursement, CRNAs administering anesthesia is more prevalent. This new study reveals that the most severe and frequent claims involved AMDs, not CRNAs. Additionally, the largest settlement value and highest total amount of settlements were allocated to AMDs. This is a relatively small sampling, and AMDs may handle more medically complex patients, but we can use this data to shift the surgeon's focus away from the type of anesthesia provider to the aspects of the case the OMD can control. This includes patient selection criteria, preoperative clearance, preoperative instructions, OMD and anesthesia provider communication prior to procedure, discharge instructions, and verifying that the facility has comprehensive policies and procedures for the credentialing and privileging of anesthesia providers and responding to emergencies.

Claim details

Although the frequency of anesthesia-related claims is relatively low, the severity of the claims can be significant and result in blindness or death. Out of the 49 cases, only 11 resulted in a settlement on behalf of our insured ophthalmologist. In 8 of those cases, the OMD was not the anesthesia provider. Six of these cases involved death of the patient. The OMD settlements were often due to allegations of improper patient selection criteria or medical clearance.

Death and globe perforations were the most common outcomes, with AMDs incurring the highest settlement amounts for both. Settlements varied widely, but cases involving an AMD and death resulted in the highest settlement of $2,000,000. The second highest settlement was a death involving a CRNA ($1,000,000) and the third highest was a retrobulbar hemorrhage administered by an OMD ($750,000). Of the 6 death cases resulting in settlement (3 AMD and 3 CRNA), allegations included lack of appropriate medical clearance, presence of significant comorbidities, and procedural complications such as oversedation, airway obstruction, distractions, and disconnected monitoring. As with most claims,

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MESSAGE FROM THE CHAIR

ROBERT GOLD, MD, OMIC Board of Directors

In the spring of 2005, I took a first step in my leadership journey at OMIC and it would lead to one of the most rewarding experiences of my career. I had recently co-presented a seminar during the annual meeting of AAPOS (the American Association for Pediatric Ophthalmology and Strabismus) with one of OMIC's risk managers, Anne Menke. Our course warned of the risk of blindness should an infant with Retinopathy of Prematurity (ROP) not be treated in time.

There is a very short window, just weeks, to diagnose and respond to ROP before it's too late, and as a pediatric ophthalmologist in Orlando, Florida, I had been worried about the potential for missing a follow up and having to deliver the devastating news to a family that their baby's sight was lost, especially if it could have been prevented. OMIC had just published *ROP: Creating a Safety Net*, a comprehensive guide designed to protect babies born prematurely from this condition. The *Safety Net* outlined protocols to ensure that no baby falls through the cracks during the coordination of care that occurs as these babies are monitored and treated for multiple issues and new parents are warned of the importance for essential treatments related to their infant's early arrival.

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EYE ON OMIC

A heartfelt thank you for many years of service

The *Digest* is published by the Ophthalmic Mutual Insurance Company (OMIC), a Risk Retention Group sponsored by the American Academy of Ophthalmology, for OMIC insureds and others affiliated with OMIC.

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OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

P 800.562.6642
F 415.771.7087
omic@omic.com
www.omic.com

Editor-in-Chief
Bill Fleming

Executive Editor
Linda Harrison, PhD

Senior Editor
Kimberly Wynkoop, Esq

Contributors
Jeannette Domask
Ryan Bucsi

Production Manager
Robert Widi

On behalf of the Board, Committees, Advisors, and staff at OMIC, we would like to extend our appreciation to Dr. Ron Pelton for his many years of service to OMIC.

At the end of 2025, Dr. Pelton will reach the maximum number of years of service allowed by our bylaws for service on OMIC's Board and Committees. Dr. Pelton has held several key leadership roles including Chair of the Finance Committee and Treasurer. During his term of service, OMIC has increased its in number of insured ophthalmologists by more than 50% and outperformed the industry in most financial and operational benchmarks for a company such as ours. We wish Dr. Pelton and his family prosperity in the years ahead.

OMIC declares another dividend to be paid in 2026

OMIC will pay our 31st dividend to physician policyholders who renew in 2026. Your dividend will appear as a 5% credit to your policy premium. This places us in a select group as less than a quarter of our industry peers paid a dividend in 2024.

While rates will be adjusted by an average 5.4%, the dividend will result in the vast majority of insureds seeing flat (or close to it) cost of insurance in 2026. Premium rate levels during the inflationary environment of the past decade have remained stable. OMIC's rates have increased an average of 2.3% while the average increase in the U.S. Consumer Price Index (CPI) was 3.3%.

MESSAGE FROM THE CHAIR

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Later that same year, OMIC asked me if I would consider providing a testimonial for the company and the *Safety Net* in their 2005 Members Report, and I enthusiastically agreed to write about my experience as an insured. I was so impressed that my insurance company had taken such a pioneering role in our profession. It had never occurred to me that the company I purchased a malpractice insurance policy from would care so much about quality of care and the safety of my patients. Of course, now it seems obvious that OMIC would be on the front lines of education. After all, the malpractice carrier is often the first organization to see what went wrong while treating our patients. It also provides the opportunity to analyze and defend our care, both to our patient and, ultimately, in the courtroom and the court of public opinion. Finally, it is good for business. The better our outcomes, the less suits and claims filed against us. While it might make perfect sense for the insurance carrier to study the intricacies of specific diseases or conditions within unique medical specialties such as ours, I have come to learn during my time serving OMIC that this level of expertise remains quite rare within the insurance industry. Traditional carriers that defend multiple specialties tend to have a shallow knowledge of each, contrasting noticeably with OMIC, which of course has a very deep level of expertise in our specialty.

During the twenty years that have followed my presentation at AAPOS, the *Safety Net* has become indispensable for my colleagues who screen for and treat ROP. I know our company has helped to protect the sight of many unknown patients who relied on our insureds for their care and that is why I am so proud of our profession's prescient funding and support for a company such as OMIC. The fact that there are few insurance companies that have followed in our footsteps - specializing in a specific field of medicine – is confounding to me considering the obvious advantages. Ophthalmologists have been richly rewarded for this as OMIC has delivered superior defense for ophthalmology, maintained stable premium rates and impressive dividends, coverage availability nationwide, and resources that are truly sight-saving for our patients. Shortly after my testimonial, the leaders of OMIC asked if I would be interested in serving on OMIC's Committees and eventually the Board of Directors. They mentioned it was a significant commitment up to 15 years, and they wanted me to be sure before I agreed. Without hesitation, I told them I needed no time to "think it over." The answer was an emphatic yes - I was in - and it was a decision that proved to be one of the best of my life.

POLICY ISSUES

Incompetency: reporting and coverage

KIMBERLY WYNKOOP, VP, OMIC General Counsel

In the lifespan of your practice, you may have to deal with physician incompetency issues. Unfortunately, you may be the impaired physician, or you may find yourself in the position of evaluating the competency of one of your peers.

When used in this article, "incompetency" refers to a physician's inability to practice safely due to mental or physical impairment, as distinct from the notion of "incompetence," which might include poor skill, training, or judgment.

When you are the physician with potential competency issues, as an OMIC-insured you have affirmative reporting duties under your professional and limited office premises liability insurance policy. Under Section VIII. General Conditions, Rules, and Duties, Subsection 2, insureds agree to update OMIC immediately, in writing, about any changes to the representations they made in their application. (The application inquires about substance abuse, mental health, and medical conditions.) If the insured fails to notify OMIC within thirty days of the change, OMIC has the right to deny coverage of a claim related to that change, or to cancel the policy.

More specifically, Subsection 3 requires insureds to give OMIC written notice within thirty days of certain specific situations, including the insured undergoing (or being advised to undergo) treatment for substance abuse or psychiatric illness and the insured suffering from an illness or physical injury that could impair his or her ability to practice ophthalmology for thirty days or longer.

Regarding group policies, the policyholder has the duty to act on behalf of all insureds under the policy. To the extent the policyholder or its representative is aware of an insured's incompetency, it has the duty to inform OMIC (see Section VIII.1 of the policy).

What occurs after OMIC is notified depends upon the specific facts and circumstances of your situation. Complete details of the impairment or incompetency must be provided, including its nature, date of origin, whether treatment has been sought, prognosis, and whether you have been cleared by your treating physician to continue practice (if applicable). Underwriting will require a letter from your treating physician or treatment program coordinator confirming this information. Underwriting will also ask if the impairment or condition has affected your licensure or hospital privileges.

OMIC will evaluate all these factors and determine whether and under what conditions OMIC can continue providing insurance coverage to you. If you are cleared by your physician and approved by OMIC for a reduced scope of practice, your coverage classification may be changed (for example from full surgery to no surgery). If you are temporarily unable to practice, you may be eligible for a suspension of coverage. If serious action has been taken against your privileges or licensure, such as suspension or revocation, OMIC may be unable to insure you. As a physician-owned carrier, OMIC is supportive of insureds facing such impairments and generally takes the least restrictive action that is prudent for the company.

For patient safety reasons, and because such claims can be extremely difficult to defend, OMIC does not cover claims arising from insureds' performance of direct patient treatment while under certain impairments. For instance, Section III.B.4. of the policy provides that OMIC will defend but not pay damages for a claim that arises out of, but is not solely limited to, an act committed while the insured is under the influence of alcohol, drugs, or other substances that adversely affect the Insured's professional ability or judgment. If the insured's condition leads to restrictions on or the loss of their licensure (including DEA license), be aware that OMIC will neither defend an insured nor pay damages for a Claim that arises out direct patient treatment that occurred in violation of a restricted or revoked license (see Sections III.A.2. and III.A.3. of the policy).

In order to financially assist insureds who leave practice due to incompetency and disability, if the insured is judicially determined to be incompetent or is permanently and totally disabled, OMIC provides the insured with free extended reporting period ("tail") coverage upon termination of the policy.

In another scenario, you may be called on to evaluate another physician's competency. OMIC's policy provides defense and payment of damages for claims arising from such evaluations when undertaken as part of professional committee activities performed for a state licensed health care facility or clinic, a professional association or society, or your insured professional entity (see Coverage Agreements C and D of the policy). Professional committee activities are services you perform while acting within the scope of your duties as a member of, participant in, or person executing the directives of a formal accreditation, credentialing, peer review, or similar professional board or committee. While the policy generally excludes any coverage for wrongful acts, OMIC will defend but not pay damages for claims that arise from your good faith performance of professional committee activities alleging wrongful acts such as slander, defamation of character, and anticompetitive activities.

Questions about how to handle incompetency? Call OMIC's risk management hotline for advice.

Anesthesia related claims from 2014-2024

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higher settlements correlated with cases involving younger patients (as their longer life expectancies mean greater economic loss and loss of enjoyment of life, and longer duration of medical needs). Two of the deaths attended by CRNAs lacked clearance and involved high risk patients.

Comparing claims resulting in death and globe perforation in the two studies, we see a shift in the provider who administered the anesthesia when claims resulted. In the prior study of 63 cases, there were 13 deaths and the majority (6) involved the OMD administering the anesthesia, followed by AMDs (4), CRNAs (2), and one unknown provider. In the current study of 49 cases, there were 17 deaths and the majority involved anesthesia administered by the AMD (9), then the CRNA (7), then the OMD (1). In the prior study there were 17 cases of globe perforations with 12 attributed to OMDs, 3 to AMDs, and 2 to CRNAs. In this study there were 15 globe perforations with 8 attributed to AMDs, 5 to OMDs, and 2 to CRNAs.

High frequency and severity claims: death and globe perforation

The most frequent adverse outcome in the study was death. In the 17 deaths, all the patients had at least one comorbidity and most had multiple, which increased the risks related to anesthesia. The most common comorbidities were cardiac disease and diabetes. Intravenous sedation was used in 11 cases, general anesthesia in 5, and oral sedation in one. The types of surgeries included 10 retina, 4 cataract, and 3 other anterior segment procedures. There was variation noted in how medical clearance was handled. The best practice is for the surgeon to identify any high-risk medical conditions that need medical clearance from primary care or a specialist and refer the patient to obtain the clearance. We do not recommend leaving the clearance solely up to the anesthesia provider the day before or day of the procedure. We advise developing a policy and procedure that includes patient selection criteria and medical clearance guidelines to ensure compliance within the practice.

The second highest injury frequency was globe perforation (15). Globe perforations were a result of a peribulbar block (9) or a retrobulbar block (6) and all involved significant vision loss. These are known complications but still result in settlements due to allegations of risky anesthetic choice, improper technique, failure to recognize injury, and improper informed consent. In this study, most of the globe perforation cases involved cataract surgery (11). These results indicate that the provider should consider topical anesthesia as a first choice for non-complicated cases, and reserve blocks for more complex or longer surgeries. OMDs should confirm that AMDs or CRNAs performing blocks have proper credentialing and privileging at the surgery facility since most AMDs and CRNAs learn how to perform blocks on the job. The Betsy Lehman Center issued an expert panel report on Advancing Patient Safety in Cataract Surgery in 2016, and it contains valuable information on this topic.

INJURY FREQUENCY BY ANESTHESIA PROVIDER (MOST FREQUENT INJURIES)

Provider	Injury	Frequency
AMD	Death	9
AMD	Globe perforation	8
CRNA	Death	7
OMD	Globe perforation	5
OMD	Retrobulbar hemorrhage	4
OMD	Pain	3
AMD	Pain	3
CRNA	Globe perforation	2
OMD	Death	1
OMD	Nerve injury	1

Other less frequent injuries in the study claims included pain during procedure (6), retrobulbar hemorrhage (5), nerve injury (2), brain stem/anoxic brain injury (1), cardiac event (1), fire (1), and vitreous hemorrhage (1). Based on these two studies of anesthesia-related claims in ophthalmology cases at OMIC, the data does not show that CRNAs are causing increased liability for ophthalmologists. From a risk perspective, concentrating on the aspects of the case that are within the control of the surgeon is where the liability mitigation should be focused.

Focus on what the surgeon can control

Patient selection criteria are essential to determine if a patient is a candidate for a particular procedure, which sedation level is appropriate, and what setting is reasonable. The need for medical or medication clearance, or guidance from other providers should be assessed before the procedure. Determining if any medications should be held and fasting timelines should be included in pre-procedure instructions. Surgeons and anesthesia

OMIC SETTLEMENT AMOUNTS BY SEVERITY AND ANESTHESIA PROVIDER

Provider	Injury	Settlement
AMD	Death	$2,000,000
CRNA	Death	$1,000,000
OMD	Retrobulbar hemorrhage; vision loss	$750,000
AMD	Globe perforation	$560,000
AMD	Death	$200,000
AMD	Globe perforation	$200,000
CRNA	Death	$150,000
OMD	Retrobulbar hemorrhage	$110,000
OMD	Globe perforation	$75,000
AMD	Death	$25,000
CRNA	Death	$20,000

providers should have a briefing prior to the procedure. They should discuss the type of sedation to be used, and both should be involved in the decision. Surgeons and anesthesia providers should also discuss any medical concerns specific to the patient. In addition, if there is a fire risk, discuss the plan to mitigate that risk. Discussion with the patient of risks for elective procedures under sedation should be thoroughly consented to and documented in the medical record by the surgeon and anesthesia provider. Discharge instructions should be provided to inform the patient of symptoms that require emergent care, when to restart any held medications, and follow-up visit requirements.

Supervision of CRNAs or RNs

You may be asked to supervise a CRNA due to federal law if your state has not "opted out" of the physician supervision requirement. In some states CRNA scope of practice also allows them to practice independently. The majority of the "opt out" states allow CRNAs to practice independently, but this is not always the case as the maps illustrate. CRNAs will be held accountable for the standard of care in their scope of practice. Agreeing to sign off on the supervision of the CRNA does not mean the ophthalmologist has agreed to accept the liability exposure of an anesthesiologist, but your role as their supervisor could result in liability for their acts or omissions. Courts focus on the amount of control the physician exercises over the anesthesia provider, whether a CRNA or anesthesiologist. Establish standardized protocols for anesthesia administration with input from anesthesiologists to ensure consistency, best practices, and alignment with evidence-based guidelines.

Due to the anesthesia provider shortage, RNs have been delegated to administer anesthesia in some settings and it is common in office-based surgery in states that permit the practice. This would require the surgeon to serve as the RN's supervisor, which can create liability exposure. In most states (except Utah) it is within the scope of practice for RNs to administer anesthesia provided they have the knowledge and skills to administer these medications safely. There are potential risk concerns if the RN does not have the background, skills, experience, and education to recognize complications or rescue a patient who goes into deeper sedation. Competency of an RN administering anesthesia and monitoring patients should be assessed to mitigate risk.

Lastly, there have been instances where the ophthalmologist was asked to serve as both the anesthesia

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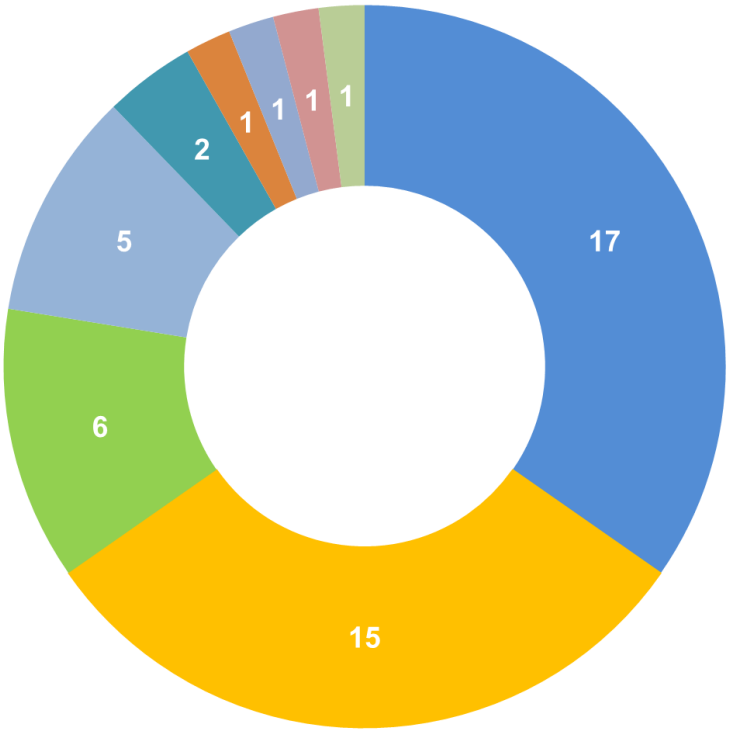
Distribution of Anesthesia Outcomes (2014-2024)

INJURY TYPES



CLOSED CLAIM STUDY

A fire in the OR during COVID

RYAN M. BUCSI, OMIC Claims Vice President

Allegation

Fire in the operating room.

Disposition

Settlement of $355,000.

An OMIC insured ophthalmologist performed an elective cosmetic four-lid blepharoplasty with fat removal from the lower lids. The case was performed during the COVID pandemic, so the patient was required to wear a mask during the surgery. The mask was supplied by the surgery center and was the common paper mask used in medical settings. The patient was receiving oxygen by nasal cannula, the mask was on over the nose/mouth, and the patient was covered by a surgical drape starting just under the eyes.

When the surgeon started the fat removal portion of the procedure an Elman cautery unit was used to make the incisions. During this procedure there was a "flash-over" from the cautery and a puff of smoke. The drape was pulled off and, as the insured was holding the clamp in one hand, the other hand was patting out spots of fire, which extended to the mattress pad of the OR bed.

An OR nurse immediately poured a bucket of water on the patient's face. The mask had "vaporized" and there was nothing left of it. There were superficial burns around the patient's mouth, nose, and chin where the mask had been. There were also burns along the ear and hairline where the mask's ear straps had been and on the back of the patient's shoulder where the mattress pad had melted.

The insured ophthalmologist then examined the patient's nose and mouth and did not see any sign of internal burns. They quickly removed the fat from one lower lid and sutured all four lids and applied ointment to the burned areas of the skin. EMS was called and the patient was taken to a local hospital burn unit.

The patient was evaluated in the emergency room by a plastic surgeon who debrided a small area of the lip. The patient returned for one last post-operative visit 5 days later. The insured noted the burns seemed to be healing well and looked like a "bad sunburn." The patient had approximately one year of treatment for a raised scar area with some residual scarring and hypopigmentation.

Analysis

The plaintiff filed a lawsuit and retained an expert witness who specialized in plastic surgery, who stated that blepharoplasty is known as a high fire risk surgery due to the use of electrical cautery near an oxygen source and other flammable products. This expert also opined that there was a failure to communicate between the surgeon and the anesthesiologist to ensure that no oxygen was flowing and that any accumulated oxygen was allowed to dissipate prior to the use of cautery. Had this occurred, there would not have been enough oxygen accumulated to pose a fire risk.

OMIC was unable to find an expert to support the care that was provided. Since this was a clear case of liability, a settlement of $355K was negotiated on behalf of the OMIC-insured surgery center.

Takeaway

Most operating rooms use a fire risk scoring system under which the highest risk is associated with a combination of surgery above the xiphoid, an open oxygen source, a fuel source (mask or drape), and an ignition source such as electrocautery. All of these were present for this patient's surgery.

The ASC records did not show that a fire risk assessment was conducted for surgery, although all nurses, managers, and anesthesia providers would be expected to be aware of the possibility of fire. There was no clear standard of care for monitored sedation during the COVID pandemic. However, the use of nasal cannula oxygen under a mask is not widely accepted.

The combination of mask, oxygen, and cautery would have been clearly unacceptable before the pandemic since it is known that the collection of oxygen under drapes or a mask is extremely dangerous. A small survey of ophthalmologists demonstrated that 67% performed surgery in places that did not use COVID masks on patients in the operating room. 33% did, but in those cases, the surgeon waited 1-2 minutes after the oxygen was turned off before using cautery to permit the oxygen to dissipate from under the mask and consequently reduce the fire risk.

NEWS

Coverage enhancements coming in 2026

OMIC has broadened the coverage provided to insureds in their Professional and Limited Office Premises Liability Insurance policy effective January 1, 2026. The following is a summary of the expansions:

- The policy will specifically **include coverage for the use of artificial intelligence tools** in the provision of direct patient treatment.
- The amount **OMIC will pay for an insured's loss of earnings resulting from attendance at a court proceeding** involving a claim will increase from $500/day, $250/half day to $2,500/day, $1,250/half day (maximum $25,000).
- Coverage for **defense of disciplinary proceedings will extend to all licensed health care professionals**.
- OMIC will **waive the premium for an extended reporting period endorsement** (i.e., OMIC will provide a "free tail") **to insureds who completely leave private practice teach** at an accredited academic institution.

These policy changes will apply to all insureds (regardless of renewal date) on 1/1/2026.

The updated policy form showing these changes, will be available by signing into your MyOMIC account on our website (or let us know you'd like a hard copy by emailing omic@omic.com or calling us at (800) 562-6642.

New claim benefit

OMIC is piloting the Defense LEAP program (Litigation Education and Performance) that Dr. Gita Pensa has designed for physicians navigating the claim defense process. We have been working to try to change the litigation experience of our insureds, and know there are a lot of factors that make litigation difficult for them.

One thing we know tends to drive stress around malpractice litigation is a lack of understanding of the law and legal events, or "how this all really works" in real circumstances. Another part is distress at the thought of being deposed or even going to trial, and not really knowing anything about how to do that, which can create a lot of fear and anxiety.

Traditionally we have left this to our highly skilled defense attorneys, and the teaching happens closer to the time of deposition, but we understand now that many defendants can benefit from knowledge earlier in the process, and that having this knowledge can help with their overall anxiety about the lawsuit. We also know that for some doctors, stress over litigation or the medical events that led to it can change how they feel about work or how much they feel they can enjoy life. This can create a lot of hardship for these physicians and their families.

Dr. Pensa, who is a well-being and performance coach for defendants in litigation, has created a course to teach defendants about all of those things, as well as the coaching strategies she uses with her individual and group clients. We encourage our insureds to participate in this new program should they be the subject of a claim or lawsuit.

Dr. Pensa is well known in this field and has a podcast that many physicians find helpful, called 'Doctors and Litigation: The "Doctors and Litigation: The L Word." She has worked with many physicians as a coach and educator in 1:1 settings, small groups, and in large lectures. She is an emergency physician who was sued herself in a high-demand stroke case, and wound up dealing with it for twelve years, including going to trial twice. She struggled for years with litigation stress, and how to be a "good defendant" – while still living her life and doing good work. The LEAP Course is designed to:

- Increase your understanding of the litigation process and your role in defending your case
- Impart foundational skills for performance as a deponent and potential trial witness
- Create a framework for understanding litigation stress, and how to recognize and mitigate its impact on your life and your work.

The course consists of modules of short videos, and can be done over time. In all there is about 6 hours of content. It is provided by OMIC at no cost to you, and during the pilot program, you can earn free CME credits (up to 6 hours). More information on this program can be found at https://doctorsandlitigation.com/.

Anesthesia related claims from 2014-2024

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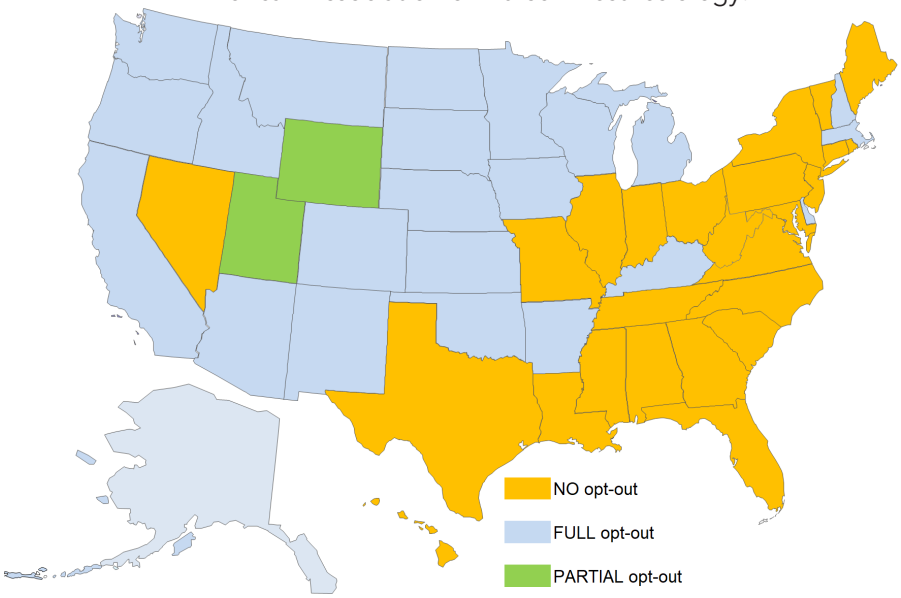
provider and surgeon during a procedure. This is not recommended from a risk or liability perspective if there is not a licensed health care provider present to monitor the patient. The surgeon performing the procedure should not be responsible for administering the anesthesia and monitoring the patient. There are patient safety considerations and liability risks associated with this situation due to the lack of background, skills, experience, and education of the ophthalmologist in the role of anesthesiologist, as well as the distraction of the ophthalmologist from their focus on the procedure.

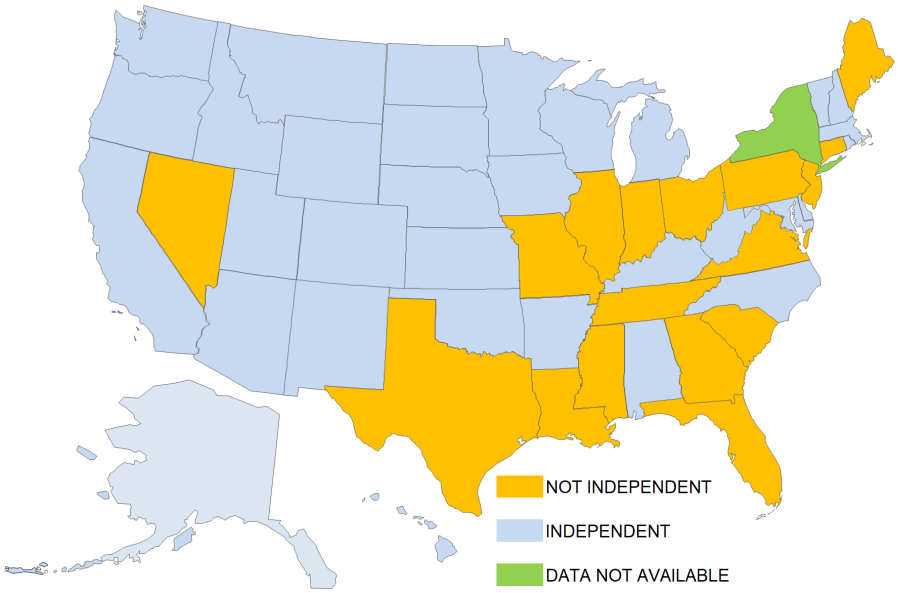
ASCs can be found liable for negligent hiring, training, and credentialing of staff employed or contracted at the facility. Every state has different statutes, case law, and scope of practice guidelines that apply depending on the facts and allegations of the case. To ensure the competence of CRNAs and RNs, discuss with the ASC administration their policies and procedures for credentialing, privileging, and training these anesthesia providers. Emergency drills should be conducted with all staff. Any competency concerns of anesthesia providers should be brought to the attention of the ASC administration immediately.

This article provides valuable data for insured practices to use when implementing procedures and protocols for anesthesia providers. When developing a plan, consider the following risk management recommendations:

Practice in Your State: Opt-out map. (2024)
American Association of Nurse Anesthesiology.



CRNA Independent Practice Map. (2024).
National Council of States Board of Nursing.



Policy Development

Establish or revisit policies and procedures for patient selection, preoperative risk assessment, sedation, monitoring, and discharge.

Anesthesia Choice

Communicate with providers prior to the procedure regarding anesthesia choice, patient comorbidities, and potential for fire risks. Use the least invasive form of anesthesia appropriate to the case.

Credentialing and Privileging

Verify with the facility (or ensure if you are the owner) competency of anesthesia providers using comprehensive policies for credentialing, privileging, and evaluation of the provider, including anesthesia choice, patient comorbidities, and potential for fire risks.

Emergency Preparedness

Ensure or confirm with the facility readiness for complications that require a coordinated response to an emergency, such as respiratory distress or fire, which should include policies and procedures and periodic simulation drills.

ACLS certification

Ensure the surgeon supervising a CRNA or RN has ACLS certification.

Lead article references:

Related resources on OMIC.com
- *Anesthesia Liability (course)*
- *Anesthesia Liability (recommendations)*
- *Ambulatory Surgery Centers (recommendations)*

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AAO Journal. (2015). Fires in the OR: Prepare and Prevent. https://www.aaojournal.org/article/S0161-6420(14)00828-8/fulltext.