F8 Is Communication Between the Surgeon and the Anesthesiologist Really Necessary? What Are the Medicolegal Implications?

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Learning Overview: The goal of this presentation is to evaluate the existence of bad communication between doctors in the operating room in a clinical case of professional responsibility.

Impact on the Forensic Science Community: This presentation will impact the forensic science community by informing attendees how a lack of or bad communication between an anesthesiologist and an ear surgeon prevented correct management of the clinical case, determining the fatal outcome.

Background: Ineffective team communication is often the cause of medical errors. This story begins with a serious error by an anesthesiologist.

Clinical Case: The incident, which occurred in December 2007 at the Hospital of Vibo Valentia (Calabria), is inherent in the death of a 16-year-old girl hospitalized with a peritonsillar abscess with edema.

On December 1, 2007, the girl was visited by the family doctor who diagnosed tonsillar abscess and prescribed an antibiotic and cortisone. This was followed by hospitalization after a few days. The patient was visited by the head of the Otorhinolaryngology department of the aforementioned hospital. Peritonsillar abscess with edema was diagnosed. Therapy with intravenous and cortisone cephalosporins was prescribed but did not prevent the progression of the disease. The morning after admission, the young woman was taken to the operating room for a tracheotomy, which was necessary due to the disease progression, which compromised the airways.

The anesthesiologist tried twice to give general anesthesia with curare and intubation; but without results. The myorelaxant effect of the curare caused paralysis of the respiratory muscles with consequent total occlusion of the respiratory tract. Anoxia occurred with desaturation. In this dramatic contingency, the anesthesiologist tried to perform an emergency tracheotomy, but without success. Death from cardiocirculatory arrest occurred following pharmacologically induced asphyxia. The autopsy conducted on the girl's body showed that the scalpel had also caused a lesion on the esophagus and a lesion of the large neck vessels.

At the end of the judicial procedure, the six doctors, including otolaryngologists and anesthesiologists, accused of manslaughter were sentenced.

Conclusions: The sentence of the Cassation of May 5, 2015, states that bad teamwork has given way to human error responsible for the death of the girl.

The Court of Cassation observes that, "Teamwork sees the institutional cooperation of different subjects, often bearers of distinct competences," placing itself perfectly in line with its own jurisprudence and of previous merit. It adds, however, that, "This activity must be integrated and coordinated, it must be removed from anarchism." For the first time in memory, the Supreme Court used this term referring to teamwork and drew the following conclusion: "For this reason the role of guide of the head of the work group is relevant," which "cannot disregard the whole activity of the other therapists, but must instead direct it, coordinate it."

Therefore, when the anesthesiologist makes choices related to his role as a medical specialist in his own specialty, he is personally responsible for the choices made. When, on the other hand, he proposes choices that belong to a context of common knowledge of other doctors, he re-emerges from the past role of head of the surgeon's first operator who, in the face of the refusal to adhere to the directives given by the anesthesiologist "well may suspend the activity," or, using the words of the judges of merit, dismiss the anesthesiologist.

In this case, regarding the specific multidisciplinary anesthetic question and in the face of decisions that interfered with the surgical choices of edema control, the Roman judges specify that it was up to the surgeon to decide the "weighting of the implications of curative anesthesia" with the consequence of "preventing anesthesia."

This was so true that he expressed his point of view, which turned out to be correct, but he did not draw the necessary consequence; that is, the duty to prevent anesthesia by possibly suspending the execution of the surgical procedure which, as was seen, was urgent but was not treated as such.

The lack of or bad communication between the anesthesiologist and ear surgeon prevented the correct management of the clinical case, determining the fatal outcome.

Medical Communication, Teamwork, Medical Error