Capitalize on the Growth of Outpatient Surgery Anesthesia Cases
© 2013 Vickie Milazzo Institute, a division of Medical-Legal Consulting Institute, Inc., Houston, Texas.

No part of this work may be reproduced or transmitted in any form or by any means, digital, electronic or mechanical, including photocopying or scanning, or by any information storage or retrieval system without permission in writing from Vickie Milazzo Institute.

DISCLAIMER OF WARRANTIES

THIS ADVANCED CLNC® PRACTICE-BUILDING PROGRAM PROVIDED BY VICKIE MILAZZO INSTITUTE ("INSTITUTE") IS TRANSFERRED AND SOLD TO THE PURCHASER WITHOUT ANY WARRANTIES BY THE INSTITUTE, WRITTEN OR ORAL, EXPRESS OR IMPLIED, INCLUDING WARRANTY OF MERCHANTABILITY, FITNESS FOR PARTICULAR PURPOSE, USE, OR OTHERWISE. SUCH MATERIALS ARE SOLD ON AN "AS IS" BASIS AND THE INSTITUTE ASSUMES NO LIABILITY OR RESPONSIBILITY FOR ANY SUBSEQUENT USE BY PURCHASER.

END-USER LICENSE AGREEMENT

This educational material is copyrighted by Medical-Legal Consulting Institute, Inc./Vickie Milazzo Institute, and is provided to the original licensee under a personal education license. This material may not be transferred, sublicensed, resold, reproduced, copied or otherwise redistributed in whole or in part in any form without prior written permission of the licensor. By opening and continuing to use this material you agree to the terms of such license.
CAPITALIZE ON THE GROWTH OF OUTPATIENT SURGERY ANESTHESIA CASES

CONTENTS

I. Introduction .................................................................................................................. 1

II. Common Outpatient Anesthesia Cases .................................................................... 2

III. Common Plaintiff Allegations for Outpatient Anesthesia Cases ............................ 2

IV. Common Defenses for Outpatient Anesthesia Cases ............................................. 4

V. The Role of the Certified Legal Nurse Consultant CM in Outpatient Surgery Anesthesia Cases ........................................................................................................ 6

VI. Interrogatories and Requests for Production .......................................................... 8

VII. Recommended Qualifications for CLNC® Subcontractors for Outpatient Surgery Anesthesia Cases ........................................................................................................ 11

VIII. Case Studies .......................................................................................................... 12

IX. Resources ................................................................................................................ 16
CAPITALIZE ON THE GROWTH OF OUTPATIENT SURGERY ANESTHESIA CASES

I. INTRODUCTION

A. Approximately 24 Million Procedures Performed Each Year

1. 65% of all surgeries are performed in outpatient setting.

2. Many sites perform outpatient surgery.
   a. Hospitals.
   b. Outpatient surgical centers.
   c. Office surgery suites (plastic and general).
   d. Dentists’ office.

3. The list of procedures performed in outpatient settings continues to grow. *(Exhibit A)*
   a. Laparoscopic lap band.
   b. Laparoscopic cholecystectomy.
   c. Shoulder arthroscopy.
   d. Abdominoplasty (tummy tuck).
   e. Joint replacement.

4. Reasons for the increase in outpatient surgery.
   a. Less invasive surgical procedures.
   b. Improved equipment (fiber optic scopes vs. rigid).
   c. Improved anesthetic medications.
   d. Improved postoperative analgesic techniques.
   e. Financial.

   a. Reasonably healthy patient. *(Exhibit B)*
   b. Minimal or controllable postop pain.
   c. Postop care not requiring a nurse or physician.

B. Accidents and Errors Occur with Devastating Results

1. Any mistake that can occur in a hospital operating room can occur in any operating room, regardless of location.

2. Outpatient surgery is viewed as low-risk surgery on healthy patients – complications are seen as rarities.
II. COMMON OUTPATIENT ANESTHESIA CASES

A. Failed Intubation – Airway Mismanagement
   1. Poor airway. (Exhibit C)
   2. Obese patients (difficult airway, sleep apnea).
   3. Pediatric patients (inappropriately sized equipment).

B. Hypoxia in the Postoperative Period Resulting in Death or Brain Damage
   1. Excessive narcotics resulting in respiratory depression.
      a. May be compounded by other concurrent medications.
   2. Insufficient reversal of skeletal muscle relaxants.
   3. Poor airway control (patients with obstructive sleep apnea).

C. Nerve Damage
   1. Pressure on nerve bundles (axillary, peroneal, neck).
      a. Poor positioning.
      b. Inadequate padding.
   2. Regional anesthesia.
      a. Toxic substance injection.
      b. Interneuronal injection.

D. Intraoperative Awareness Under General Anesthesia
   1. Incidence is reported at 0.3% to 0.5%.
   2. Must be differentiated from awareness during sedation.

III. COMMON PLAINTIFF ALLEGATIONS FOR OUTPATIENT ANESTHESIA CASES

A. Failure of Anesthesia Provider to Monitor Patient, Resulting in
   1. Anoxia, hypoxia or inadequate ventilation.
      a. Intubation problems.
      b. Intraoperative hypoxia.
c. Hypercarbia from hypoventilation.
d. Poor airway management in postoperative period.

2. Inappropriate intraoperative management.
a. Inadequate blood or fluid replacement.
b. Organ failure from hypotension.
c. CVA from hypertension.
d. Poor blood sugar control.

3. Organ damage from positioning.
a. Nerve damage.
   (1) Peroneal nerve.
   (2) Brachial plexus.
b. Muscle damage from lack of support or padding.

B. Failure of Anesthesia Provider to Communicate with the Medical Team, Resulting in

1. Inappropriate anesthetic choice.
a. Lack of medical consultation (hematology, cardiac, etc.).
b. Lack of complete preoperative evaluation.

2. Inappropriate patient selection.
a. Multiple medical conditions.
b. No one to care for the patient postoperatively.

3. Wrong patient surgery.
a. Not reviewing history and physical.
b. Not reviewing consent form.
c. Not participating in “time out” procedure with all staff.

4. Lack of coordination between surgeon and anesthesia.
a. Failure to appreciate blood loss or need for replacement.
b. Failure to communicate the urgency of the situation.
c. Failure to discuss appropriateness of case for the surgery center (length of case, complexity).

C. Failure of Anesthesia Provider to Communicate with Patient, Resulting in

1. Lack of informed consent.
a. Speaking beyond the patient’s level of comprehension.
b. Not answering patient’s and family’s questions.
c. Failure to disclose known, common complications.
d. Failure to obtain interpretive services.
2. Lack of a complete preoperative evaluation.
   a. Assuming items not supported by fact.
   b. Asking questions not understood by the patient.
   c. Receiving questionable information from family members.
   d. Failure to confirm NPO status.
   e. Failure to recognize complications from OTC drugs.

3. Lack of appropriate preoperative care.
   a. Medication management.
   b. Excessive sedation before the procedure.

D. Failure to Diagnose Resulting in
   1. Pneumonia from aspiration.
   2. Hypoxic brain damage.

E. Failure to Refer Resulting in
   1. Delay of appropriate therapy.
   2. Inappropriate discharge to home.

F. Failure to Treat Resulting in
   1. Poor glucose regulation (hypoglycemia, hyperglycemia).

G. Psychological Trauma, Resulting from Intraoperative Awareness

H. Delay in Response or Treatment
   1. Changes in patient’s condition.
   2. Lack of sufficient monitoring.

IV. COMMON DEFENSES FOR OUTPATIENT ANESTHESIA CASES

A. Adherence to Appropriate Standards of Care
   1. Sources of standards.
      a. American Society of Anesthesiologists.
c. Credentialing agencies.
d. Industry organizations

2. Appropriate use of monitors given the patient’s condition.
   a. Invasive v. noninvasive monitoring.
   b. End tidal carbon dioxide measurement.
   c. Pulse oximetry.

3. Appropriate preoperative evaluation.
   a. Patient history (medical and anesthetic).
   c. Airway with regard to possible difficult intubation.
   d. Airway with regard to possible postop difficulty.
   e. Current lab, radiologic and other tests.
   f. Review of current medications.

B. Consent Was Informed, Clear and Complete

1. Appropriate documentation.
   a. Consent included common, foreseeable complications.
   b. Preoperative assessment included patient specific items and plan to deal with them.
   c. Patient and family questions were answered to their satisfaction.
   d. The conversation took place in a language that the patient was conversant in.

C. Patient Did Not Provide Critical or Complete Information

1. Previous anesthetic complications.

2. Previous surgical procedures.

3. Current medication history, including.
   a. Prescription medication.
   b. Herbal medications and therapies.
   c. Illegal drug use.

4. Incorrect information concerning last oral intake (NPO status).

5. Incorrect information about past medical history.

D. Patient Noncompliance

1. Patient participated in contraindicated activities (driving, operating dangerous equipment, etc.).
E. Allegation Is the Fault of Other Providers
   1. Failure of other practitioners to optimize the patient for surgery.
   2. Failure of others involved to follow correct procedures.

V. THE ROLE OF THE CERTIFIED LEGAL NURSE CONSULTANT®
   IN OUTPATIENT SURGERY ANESTHESIA CASES

A. A Complete Review of the Anesthetic Record by a CLNC® Consultant
   Is Invaluable to Either the Plaintiff or Defense Attorney
   1. Detect slight differences in charting by various parties.
   2. Decipher the highly technical language inherent in such cases.
   3. Review credentialing and accreditation procedures.
   4. Fully define terminology that may be commonly misunderstood.

B. Decipher the Anesthesia Record
   1. Explain abbreviations. (Exhibit D)
      a. The Joint Commission only specifies a list of prohibited
         abbreviations.
      b. Many abbreviations may be specific to a certain practice,
         locale or educational background.
   2. Explain monitors (purpose, use and limitations).
   3. Explain vital signs records (what was or was not recorded, how it
      was obtained, reason for variations, means to verify information
      charted).
   4. Explain medication administered, the reason for it and its expected
      outcome and any residual effects.
   5. Explain positioning for administration of anesthesia and for the
      procedure.
      a. Relevance of various organ systems to choice of anesthetic.
      b. Significance of patient condition to choice of anesthetic
         technique.
      c. Airway evaluation.
C. **Compare the Anesthesia Record with Other Records**

1. Check for agreement between preop evaluation and available test data.
2. Review office records from the surgeon prior to surgery.
3. Check for agreement with other records (intraoperative, postanesthesia).

D. **Locate Testifying Experts**

1. Physicians.
2. Nurse anesthetists.
3. Supporting specialist (cardiologist, pulmonologist, etc.).

E. **Research Regarding Defendant**

1. Training (basic and specialty).
2. Proficiency in regional analgesia/anesthesia.
3. Continuing education.
4. Recertification.
5. Disciplinary record.
7. License actions, discipline or complaints.
8. Health status including any medications.

F. **Research Regarding Testifying Experts**

1. Training (basic and specialty).
2. Recent clinical practice.
3. Testifying experience.
   a. Look for any change in opinions over time.
5. Social networking information.
VI. INTERROGATORIES AND REQUESTS FOR PRODUCTION

A. Interrogatories Directed to the Defense

1. Please describe the regularly scheduled maintenance performed on the anesthesia equipment and associated physiologic monitors at (Facility) __________ from (Date) __________ to (Date) __________. [Routine calibration of monitors and anesthesia equipment is necessary and is usually performed by trained personnel who are either under a service contract or employed by the facility’s biomedical department.]

2. Please list the individuals who performed any repair or regularly scheduled quality control of the anesthesia equipment at (Facility) __________ from (Date) __________ to (Date) __________ and describe their minimum and advanced qualifications. [Essential to know if the personnel performing the service had factory training or equivalent training in that specific equipment.]

3. Please describe the anesthesia machine used to administer anesthesia to (Plaintiff) __________ on (Date) __________ including:
   a. Purchase date.
   b. Where purchased.
   c. What date the unit was placed into service.
   [Need to know how long this particular piece of equipment has been in service. Is old equipment still supported by the manufacturer?]

4. Please describe the equipment used to monitor (Plaintiff) __________’s vital signs and the anesthesia record-keeping system in use on (Date) __________ at (Facility) __________.

5. If a computerized anesthesia record-keeping system was in use at (Facility) __________ from (Date) __________ to (Date) __________ please describe the system including:
   a. Data input methods (automatic vs. manual).
   b. Data storage.
   c. Backup procedures in effect from (Date) __________ to (Date) __________.
   d. Security procedures to limit access to patient data from (Date) __________ to present.
   e. Software provider.
   f. System upgrades (software and hardware).
6. Please describe the initial credentialing and periodic recredentialing process for anesthesia providers at (Facility) __________ that were in effect from (Date) __________ to (Date) __________. [The first date should precede the credentialing cycle date of the defendants.]

7. Please describe the minimum education and certification requirements for anesthesia providers at (Facility) __________ in effect from (Date) __________ to (Date) __________ including the process used to confirm this information. [The first date should encompass the recertification period immediately preceding the incident date.]

8. Please describe the procedure and the equipment that was used for a difficult tracheal intubation at (Facility) __________ from (Date) __________ to (Date) __________.

9. Please describe the process used at (Facility) __________ from (Date) __________ to (Date) __________ to prepare a patient for anesthesia prior to the procedure or surgery.

B. Interrogatories Directed to the Plaintiff

1. Please list any healthcare providers (Plaintiff) __________ has visited or received professional advice from in the past two years.

2. Please list all medications used by (Plaintiff) __________ in the past year and the reason for their consumption. [Herbal and OTC medications can have a significant impact on various organ systems.]

3. Please list any and all procedures requiring anesthesia of any kind, (including childbirth) that (Plaintiff) __________ has had from (Date) __________ to (Date) __________.

4. Please explain why (Plaintiff) __________ chose (Facility) __________ to have their procedure/surgery.

5. Please describe in detail (Plaintiff) __________’s recollection of events on the day of the procedure in question at (Facility) __________. [Plaintiff may not recall some events due to the effect of medications received.]

6. Please explain why (Plaintiff) __________ is questioning the anesthesia care provided and when patient first became concerned.
C. Requests for Production Directed to the Defense

1. Please provide a copy of the service records for all anesthesia equipment used in (Plaintiff) __________’s care on (Date) ___________ at (Facility) __________.

2. Please provide a copy of the audit trail and the security audit trail for the anesthesia computer record-keeping system used specific to the care of (Plaintiff) __________ from (Date) __________ to (Date) __________. [The audit trail is useful in determining if any of the information was changed, when it was changed, by whom, from what computer and what the original information was. The security audit trail can show who accessed and viewed the information even if it was not changed.]

3. Please provide a copy of the work schedule for (Defendant) __________ including:
   a. Time on call.
   b. Any time worked on call from (Date) __________ to (Date) __________. [The information requested is not specific to the facility where the allegation occurred since many anesthesia providers may practice at more than one facility. The purpose of this question is to look for possible fatigue factors.]

4. Please provide a copy of the policy or procedure in effect at (Facility) __________ from (Date) __________ to (Date) __________ approved by the institution for patients with known or suspected malignant hyperthermia.

5. Please provide a copy of the policy or procedure in effect from (Date) __________ to (Date) __________ at (Facility) __________ approved by the institution for patients with known or suspected latex allergy.

6. Please provide a copy of the approved policy or procedure in effect from (Date) __________ to (Date) __________ at (Facility) __________ for patients with a known or suspected difficult airway.

7. Please provide a copy of the medical staff bylaws in effect from (Date) __________ to (Date) __________ for (Facility) __________. [Bylaws may contain surgeon and anesthetist responsibilities, required preop testing and other items of interest.]

8. Please provide a copy of any policy or procedures relating to anesthesia at (Facility) __________ that were in effect from (Date) __________ to (Date) __________. [Anesthesia-related sections
may appear in the nursing, obstetrical, radiology or policy and procedure manuals outside of the main operating room.]

D. Requests for Production Directed to the Plaintiff

1. Please provide a copy of (Plaintiff) __________’s results from any cardiac testing performed from (Date) __________ to (Date) __________.

2. Please provide a copy of (Plaintiff) __________’s pulmonary function tests performed from (Date) __________ to (Date) __________.

3. Please provide a copy of the anesthesia record for any anesthetics administered to (Plaintiff) __________ from (Date) __________ to (Date) __________ at (Facility) __________. [This should probably encompass a three- to five-year time frame.]

4. Please provide a copy of all prescriptions given to (Plaintiff) __________ by any healthcare practitioner prior to surgery from (Date) __________ to (Date) __________.

VII. RECOMMENDED QUALIFICATIONS FOR CLNC® SUBCONTRACTORS FOR OUTPATIENT SURGERY ANESTHESIA CASES

A. Basics

1. RN, ARNP (nurse practitioner).

2. Experience with standards of care for anesthesia-related care that were in effect from (Date) __________ to (Date) __________.

B. Certifications

1. Nurse anesthetist (CRNA).

2. OR nurse (CNOR).

3. PACU nurse (CPAN).

4. Risk manager (LHRM).

5. Certified Life Care Planner (CLPC).

VIII. CASE STUDIES

A. Positioning for Outpatient Shoulder Surgery

1. Facts of the case.
   a. Elective left shoulder surgery.
   b. Surgery performed in the sitting position under general anesthesia.
   c. Chin and forehead were secured with straps.
   d. Plaintiff has had numbness on the left side of her face, neck and shoulder.

2. Plaintiff allegations.
   a. Surgeon, anesthesiologist and one or more nurses failed to properly secure the patient’s head.
   b. The improper positioning caused pressure on nerves C2, C3 and C4.
   c. The chin strap that was applied was too tight causing damage to two branches of the trigeminal nerve.

3. Defenses.
   a. The straps were properly applied.
   b. The alleged damage would have produced indications of trauma immediately – none was noted in the nurses’ records.
   c. Defense expert witnesses testified that the trigeminal nerve’s mandibular and maxillary branches are located behind bone precluding any damage from the straps.
   d. Plaintiff’s face was previously injured during a motor vehicle accident in 2003.
   e. Nurses did not apply the surgical straps.

4. Verdict for the defense.
   a. Plaintiff counsel presented a claim based on doctrine of res ipsa loquitur (the thing speaks for itself).
      (1) The judge found that plaintiff did not establish that the injuries were the product of negligence.

5. CLNC® consultant role.
   a. Look to be sure that all possible parties are named
   b. Review for any other contributing factors (what caused the shoulder injury).
   c. Comparison of various records made during procedure.
   d. Anatomical review of the facts.
e. Correlation of statements from various people who were present.
   f. Location of testifying experts (anesthesia, neurology).

B. Cosmetic Facial Surgery in a Surgeon’s Office

1. Facts of the case.
   a. Male patient underwent cosmetic facial surgery.
   b. Patient was diagnosed with sleep apnea several months preoperatively (not revealed to surgeon or anesthesiologist).
   c. Procedure was performed in the surgeon’s office surgical suite.
   d. Patient was prearranged to recover overnight in the surgeon’s office under the care of a recovery nurse.
   e. Patient became agitated at 7:15pm. Anesthesiologist ordered sedation.
   f. Anesthesiologist left as patient was emerging from anesthesia.
   g. Surgeon left later after talking with the patient
   h. Several hours later, patient suffered a respiratory arrest and a call was placed to 911.
   i. Patient was resuscitated and transferred to ICU.
   j. Lab and neuroimaging test showed multiple organ damage and severe anoxic brain injury.
   k. Life support terminated several days later.

2. Plaintiff’s allegations.
   a. Anesthesiologist gave the recovery nurse “wide discretion” to administer further CNS depressants.
   b. Anesthesiologist left the office before patient was awake, alert and responsive.
   c. Recovery nurse failed to appreciate respiratory distress, despite monitors.
   d. Recovery nurse failed to properly administer oxygen with an ambu bag.

3. Defenses.
   a. Patient was not over sedated by the only medications that were ordered by the anesthesiologist.
   b. Anesthesiologist was within the standard of care leaving patient with an experienced RN for overnight monitoring.
   c. Anesthesiologist assessed the patient before leaving; the patient squeezed his hands upon command.
   d. Recovery nurse was solely responsible for the death by administering unauthorized medication; the patient was comparatively at fault for not advising either the surgeon or
anesthesiologist about his diagnosis of obstructive sleep apnea.

4. Verdict for the plaintiff.
   a. Anesthesiologist 20%, surgeon 25%, RN 55%.
      (1) Surgeon had patient sign an arbitration agreement.
      (2) Court ordered claims against surgeon and recovery nurse to arbitration.
      (3) Surgeon settled prior to trial.
      (4) Recovery nurse was uninsured, arbitration claim has not been dismissed.
      (5) Patient was negligent, but this was not a substantial factor in bringing about his respiratory arrest.

5. CLNC® consultant role.
      (1) State law and administrative rules.
         (a) Required monitors, medications and equipment.
         (b) Required qualifications of providers.
      (2) Professional organization guidelines and position statements.
   b. Research medication dosages, elimination and synergistic effects of other medications administered.
   c. Location of testifying experts (toxicologist, pharmacist).

C. Delay in Treatment After Surgery

1. Facts of the case.
   a. Liposuction of abdomen and neck with resultant fat embolism, bleeding, respiratory distress and death.
   b. Elective procedure performed in physician’s office.
      (1) Patient who had previous plastic surgery without complication by the same surgeon.
      (2) Anesthesia care consisted of monitoring and sedation.

2. Plaintiff allegations.
   a. Physician did not have full privileges for this procedure at a local hospital.
   b. Once a problem occurred, treatment was delayed.
      (1) Delay by telling the patient’s mother that she was slow in recovering from anesthesia.
      (2) When the decision was finally made to transfer the patient, the ambulance company was told not to use emergency lights and siren when responding.
(3) When the ambulance arrived, the patient was cyanotic and intubation of the trachea by the EMT was complicated by swelling of the neck. The nurse anesthetist should have insisted that the surgeon initiate the transfer process earlier.

c. Information concerning the patient’s vital signs was erased when the nurse anesthetist turned off the monitors. (No mention of a paper anesthesia record.)

d. The physician’s office was not certified or inspected as an outpatient surgical center. (No transfer agreement was in place with a hospital or ambulance service.)

3. Defenses.
   a. The patient was informed of the risk prior to undergoing the procedure.
   b. There was no delay in obtaining treatment for the patient.
      (1) The patient appeared well and was talking.
      (2) Once breath sounds decreased in the right lung the ambulance was immediately called.
   c. The physician’s office was not required to be certified or inspected as an outpatient surgical center.
   d. The signs of a fat embolism would not be apparent for one to two days.
   e. The delay in transport had no impact on the patient’s death as she would have died regardless of when she was transported.

4. Verdict for the plaintiff of more than $20 million.
   a. Surgeon responsible 75% and nurse anesthetist 25%.

5. CLNC® consultant role.
   (1) Research the rules and standards for outpatient surgery centers and physician office surgery.
      (a) State law and administrative rules.
      (b) Professional organization guidelines and position statements.
      (c) Effect of sedative medication and time for its elimination.
      (d) Explanation of various terms and their implications (decreased breath sounds).
      (e) Location of testifying experts.

D. Airway Problem After Knee Surgery

1. Facts of the case.
   a. Patient had arthoscopic surgery to knee.
b. At end of surgery, anesthesiologist removed the endotracheal tube.
c. After extubation, patient took several breaths and suffered a respiratory arrest.
d. Anesthesiologist intubated the patient after three attempts over an eight-minute period. Resuscitation ensued.
e. Patient died less than an hour later after transfer to a hospital.

2. Plaintiff allegations
   a. Anesthesiologist prematurely extubated the patient.
   b. After the unsuccessful attempt to reintubate, a tracheostomy or surgical airway should have been performed.
   c. Further attempts at intubation resulted in the patient’s death.

3. Defenses
   a. Anesthesiologist followed the criteria for extubation.
   b. Anesthesiologist felt comfortable with the reintubation since he had intubated the patient originally.
   c. Neither the surgeon nor anesthesiologist felt comfortable performing a tracheostomy due to the remoteness of their last experience with that procedure (more than 20 years).

4. Verdict for defense.

5. Role of the CLNC® consultant.
   a. Prepare a chronology.
   b. Review of all applicable charts for agreement.
   c. Review of emergency airway supplies, including surgical airway (Quicktrach®).
   d. Research emergency airway algorithm.
   e. Obtain and review all applicable policies and procedures.
   f. Search for experts.

IX. RESOURCES

A. Associations and Organizations

   1. Ambulatory Surgery Center Association (ASCA).
      ascassociation.org

      aana.com
3. American Society of Anesthesiologists (ASA). asahq.org
5. Society for Airway Management (SAM). samhq.com

B. Authoritative Textbooks

C. Journal Articles

D. Websites

1. Accreditation Association for Ambulatory Health Care. [aaahc.org](http://aaahc.org)


3. Difficult airway algorithm. [ether.stanford.edu/difficult_airway.html](http://ether.stanford.edu/difficult_airway.html)

4. Herbal and dietary supplement use and anesthesia (ASA). [chpnyc.org/services/BI_Anesthesiology/herbPatient.pdf](http://chpnyc.org/services/BI_Anesthesiology/herbPatient.pdf)

5. The Joint Commission. [jointcommission.org](http://jointcommission.org)
Exhibit A
Common Outpatient Procedures

Cardiovascular
  Cardiac catheterization / angiography
  Cerebral angiography
  Cardioversion
  Pericardiocentesis

ENT
  Tonsillectomy / adnoidectomy
  Endoscopic sinus surgery
  Otoplasty
  Septo-rhinoplasty
  Partial thyroidectomy

Orthopedic
  Arthroscopies (all)
  Rotator cuff repair
  Excision of herniated lumbar disc
  Reconstruction of knee ligaments
  Unicondylar knee replacement

Eye
  Cataract
  Blepharoplasty
  Radial keratotomy
  Laser surgery for retinal tear

General surgery
  Cholecystectomy (laparoscopic)
  Appendectomy (laparoscopic)
  Hernia repair (umbilical, inguinal, femoral) (open or laparoscopic)
  Lap band placement

GYN
  Tubal ligation
  Diagnostic laparoscopy
  Termination of pregnancy
  Cervical cerclage
  Myomectomy (laparoscopic)
  Endometrial ablation

Plastic
  Breast (augmentation, reconstruction, lift, reduction)
  Liposuction
  Abdominoplasty (tummy tuck)
  Face lift
Exhibit B
American Society of Anesthesiologists
Physical Status Classification System

P1  A healthy patient.
P2  Patient with mild systemic disease.
P3  Patient with severe systemic condition(s), not a constant threat to life.
P4  Patient with severe systemic condition(s) that is a continual threat to life.
P5  A gravely ill patient who is not expected to survive without the operation.
P6  Patient declared brain-dead, organs are being removed for donation purposes.

The letter ‘E’ may be added after the physical status to indicate the emergent status of the patient, e.g. P2E or ASA2E.
Exhibit C
Mallampati Classification

The classification is used as a general indicator of the degree of difficulty that may be experienced during laryngoscopy for tracheal intubation.

Class 1  Full visibility of tonsils, uvula, hard and soft palate.
Class 2  Visibility of hard and soft palate, upper portion of tonsils and uvula.
Class 3  Soft and hard palate and base of the uvula are visible.
Class 4  Only hard palate visible.
### Exhibit D
#### Common Abbreviations Seen in Anesthesia Records

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ETCO2</td>
<td>Positive end-tidal carbon dioxide.</td>
</tr>
<tr>
<td>AARK</td>
<td>Automated anesthesia record-keeping.</td>
</tr>
<tr>
<td>AIMS</td>
<td>Anesthesia information management system.</td>
</tr>
<tr>
<td>AIS</td>
<td>Anesthesia information system.</td>
</tr>
<tr>
<td>– ASP</td>
<td>Negative aspiration.</td>
</tr>
<tr>
<td>BBS=</td>
<td>Bilateral breath sounds equal.</td>
</tr>
<tr>
<td>Bupiv</td>
<td>Bupivicaine® (a local anesthetic).</td>
</tr>
<tr>
<td>CSE</td>
<td>Combined spinal-epidural.</td>
</tr>
<tr>
<td>CSF</td>
<td>Cerebral spinal fluid.</td>
</tr>
<tr>
<td>DES</td>
<td>Desflurane (Suprane®, an inhalation anesthetic).</td>
</tr>
<tr>
<td>ETT</td>
<td>Endotracheal tube (usually oral).</td>
</tr>
<tr>
<td>EPI</td>
<td>Epinephrine.</td>
</tr>
<tr>
<td>EPID</td>
<td>Epidural.</td>
</tr>
<tr>
<td>FFCSF</td>
<td>Free flow of cerebral spinal fluid.</td>
</tr>
<tr>
<td>ISO</td>
<td>Isoflurane (Forane®, an inhalation anesthetic).</td>
</tr>
<tr>
<td>LIDO</td>
<td>Lidocaine (a local anesthetic).</td>
</tr>
<tr>
<td>NRB</td>
<td>Nonrebreathing (a type of anesthesia circuit or oxygen mask).</td>
</tr>
<tr>
<td>NTT</td>
<td>Nasotracheal tube.</td>
</tr>
<tr>
<td>OSAS</td>
<td>Obstructive sleep apnea syndrome.</td>
</tr>
<tr>
<td>PNS</td>
<td>Peripheral nerve stimulator.</td>
</tr>
<tr>
<td>RSI</td>
<td>Rapid sequence intubation.</td>
</tr>
<tr>
<td>SCCA</td>
<td>Semi-closed circle absorber (a type of anesthesia circuit).</td>
</tr>
<tr>
<td>SEVO</td>
<td>Sevoflurane (Ultane®, an inhalation anesthetic).</td>
</tr>
<tr>
<td>SUX</td>
<td>Succinycholine (a rapid acting, short duration paralytic drug).</td>
</tr>
<tr>
<td>XYLO</td>
<td>Xylocaine® (a local anesthetic).</td>
</tr>
</tbody>
</table>