Beyond the OR

One-third of surgical malpractice claims involve management issues.

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Unlike surgical claims due to technical performance issues, claims from improper management of a patient are more about clinical judgment in selecting the procedure and assessing the patient's surgical risk, as well as assessing the patient postoperatively to diagnose or rule out a surgical complication in a timely matter.

Surgical management allegations account for about one-third, or 33%, of cases, and 41% of costs. These allegations of patient harm involve steps taken when managing patients preoperatively, intraoperatively and postoperatively.

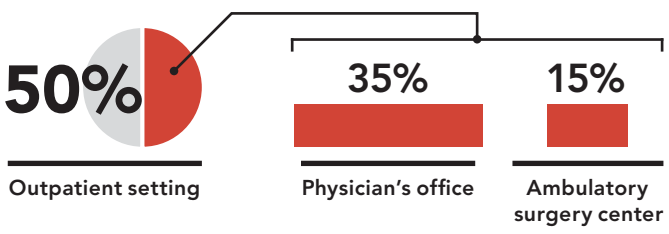
Cases involving claims of improper surgical management tend to cost more to investigate and defend, due largely to the length of time involved when postoperative diagnosis is delayed, when additional specialists and/or procedures are required, or when patient complaints go unnoticed or unresolved. These claims also involve more high-severity injuries (34%) than performance-related claims (20%), which increases costs.

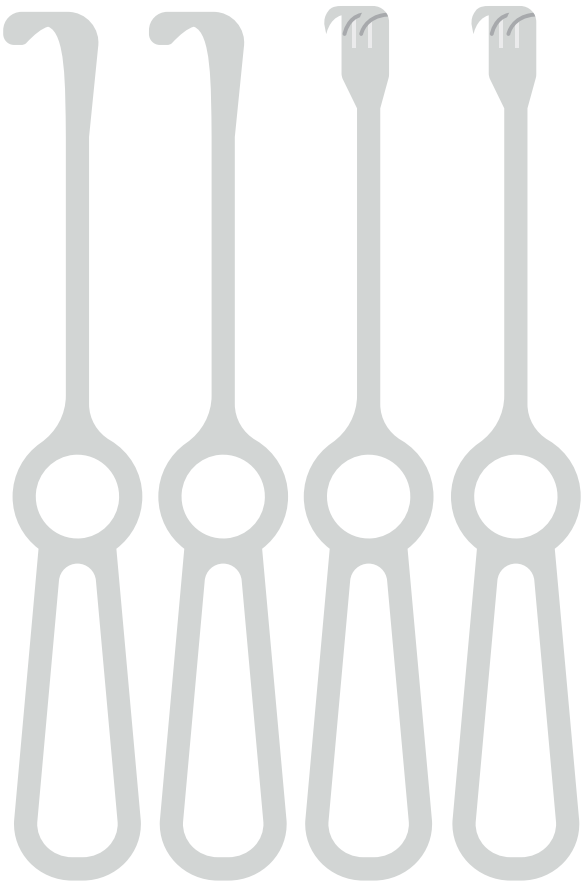
Surgical management allegations

Included in **33%** of surgery claims

Account for **41%** of costs

Where claims are happening





Communication breakdowns are more of an issue in surgical claims involving management issues vs. technical performance

Claim data show that when you have a technical performance issue in surgery, you will also likely find postoperative management issues compounding the problem. As in most claims, there can be many factors that contribute.

When looking at surgical management issues, one is likely to find a lack of communication between the surgeon and the next level of care. Things often don't get resolved soon enough, or they escalate quickly and patient harm increases.

These communication breakdowns are a key driver of surgical management-related claims. This can be patient–surgeon communication, or it can be care team communication. When it comes to communicating with other physicians, other health care team members and/or the patient and family members, our data shows that a lack of communications impacts more than half of surgical management claims.

Poor clinical judgment with patient assessment and selection of the procedure is a contributing factor in 84% of surgical management claims. Early recognition of postoperative issues and prompt action can make a significant difference, yet this doesn't always happen. It can be related to a lack of attention to medical history or failure to use available assessment tools. In the second claim example below, the pre-existing abrasion may have indicated that the patient needed preoperative antibiotics, or perhaps the procedure should have been delayed until the abrasion healed.

Patient factors may also be involved in surgical management claims. Patients may have unrealistic expectations for outcomes or recovery. They may be unhappy with the results, or they may have understood the surgery but not what was involved in rehabilitation.

Diving Deeper into the Data

The top five factors* contributing to surgical management claims include:

1. **Clinical judgment problems** (84%)
   - Poor selection/management of procedure
     - Patient assessment issues, including failure to use clinical decision support tools to assess surgical appropriateness, readiness and risk
     - Inadequate history and physical exams
   - Patient assessment issues
     - Failure to appreciate and reconcile relevant symptoms
     - Failure to respond to repeated patient postoperative complaints
     - Narrow diagnosis focus to rule out surgical complication
     - Failure/delay in ordering diagnostic tests to rule out surgical complication
   - Poor critical thinking skills
2. **Technical skill and performance** (61%)—These factors may lead to adverse outcomes that have not been recognized and managed in a timely manner
3. **Communication breakdowns** (54%)—Communication is a bigger issue with claims involving patient management vs. technical performance
   - Between patient/family and providers
     - Postoperative discharge instruction and communication failures
   - Among team
     - About the patient's condition
     - Hierarchical and handoff communication challenges
     - Lack of strong patient safety culture, including an inability to speak up
4. **Patient factors** (21%), including a patient seeking care from another physician due to dissatisfaction with the surgeon's care. Patient behavior could be related to an adverse outcome or complication combined with poor rapport with the surgeon or other communication breakdown.
5. **Documentation** (21%)
   - Insufficient, lack of or late documentation

*Note that a claim can and often does have more than one contributing factor.

Surgical Management Claims Examined

Team communication breakdown and late documentation lead to permanent disability

A surgeon removed a 51-year-old patient's existing spinal hardware and performed a lumbar spinal fusion. The evening following surgery, the man developed bilateral weakness and his nurse contacted the on-call resident who ordered her to continue monitoring the patient. Overnight the man developed complete bilateral weakness and the nurse again called the on-call resident. The resident elected not to come in and examine the patient.

The next morning the on-call resident notified the surgeon who then examined the patient and noted no motor function in the man's legs. He took the patient back to the OR for evacuation of a hematoma. The man suffered permanent disability with bowel and bladder dysfunction.

The defense of the claim was harmed because the surgeon dictated both operative reports four months following the surgeries.

Contributing factors:

- Clinical judgment
  - Failure to assess and respond to escalating patient symptoms
- Team communication failure
  - Culture issues: nurse did not speak up and use the chain of command when the resident would not examine the patient
- Late documentation
  - Operative reports dictated four months following the procedures

Lost call record leads to Staph infection and additional procedures

An orthopedic surgeon performed an arthroscopic meniscus repair on a 41-year-old woman who developed a postoperative knee infection. There were two preoperative notes from OR nursing team members concerning a preexisting abrasion on the patient's operative knee.

Two days following surgery, the patient called the orthopedic surgeon's office to report she had new swelling of that knee. There was no documentation of the call in the patient medical record. However, cell phone records confirm the patient called the orthopedist's office.

The patient went on to develop an infection in the knee and eventually had irrigation and debridement of the knee. Cultures revealed a Staph infection. She was referred to an infectious disease specialist for a persistent knee infection.

Contributing factors:

- Clinical judgment
  - Poor selection of procedure based on patient condition and risk factors
- Team communication issues
  - Failure to directly inform surgeon of abrasion
  - Failure of office team to inform surgeon of new postoperative symptoms needing attention
- Documentation deficiency
  - Failure to document patient symptom telephone call in the medical record

Poor assessment leads to potentially unnecessary surgery and complications

A general surgeon examined a 60-year-old man for right upper quadrant post-prandial pain. An ultrasound showed no gallstones. The surgeon recommended gall bladder surgery and performed a laparoscopic cholecystectomy. The day after surgery, the man called the surgeon's office with complaints of abdominal pain. He was informed that abdominal pain following surgery was normal; no exam was done.

One week later he was examined by the general surgeon for continued complaints of abdominal pain. An ultrasound showed a golf-ball-sized fluid collection in the abdomen and the surgeon recommended further evaluation if the pain continued. Two weeks later, the patient was still complaining of pain and a scan showed a probable biliary leak. An ECRP was ordered and a stent inserted for a bile leak which then caused pancreatitis. His abdominal pain persisted and he was examined at a tertiary center.

The man had an extended recovery with chronic pancreatitis and a pancreatic abscess. Experts were critical of proceeding with surgery without a HIDA scan and opined that the man did not need gall bladder surgery.

Contributing factors:

- Clinical judgment
  - Poor selection of procedure based on patient assessment
  - Improper patient assessment: no HIDA scan when ultrasound showed no gall stones
  - Failure to appreciate and reconcile relevant symptoms postoperatively
  - Failure to respond to repeated patient postoperative complaints
- Technical skill/performance
  - Known procedural risk (biliary leak) not recognized and treated in a timely manner

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Is it Technique or Management? Or Both?

Surgical claims primarily involve allegations concerning technical performance issues or management-related issues. The chart below highlights the key differences. Sometimes a claim may involve both a technical performance issue and a management issue, often due to a delay in responding to complications resulting from poor performance.

Technical Performance Issues	Management-related Issues
Involves intraoperative performance	Includes steps taken to manage the patient pre-, intra- and postoperatively
More about skill, technique and performance of the procedure	More about clinical judgment in selecting the procedure and assessing the patient's surgical risk, as well as assessing the patient postoperatively to diagnose or rule out a surgical complication in a timely manner
Communication breakdowns with the patient in obtaining informed consent	Communication breakdowns among the care team about the patient, or between the care team and the patient/family
Examples include pulmonary artery laceration during biopsy for mediastinal mass, or uterine puncture during myomectomy	Examples include delayed diagnosis of anastomotic leak after colorectal resection, or mismanagement of anticoagulation resulting in a pulmonary embolism

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