Deep Cuts

A dive into the data on surgery claims

By Lori Atkinson, RN, BSN, CPHRM, CPPS and Liz Lacey-Gotz

Surgeries continue to increase in number in the United States each year, with a significant increase in procedures being performed in outpatient surgery centers. Estimates from a 2015–2017 National Quality Forum report show that more than 100 million procedures are performed each year in surgery centers, including both inpatient and outpatient facilities.

Errors can occur and lead to surgical patient harm, as well as malpractice claims, not only in the performance of surgery but also in the preoperative and postoperative phases, and they can involve both technical skill issues and patient management issues.

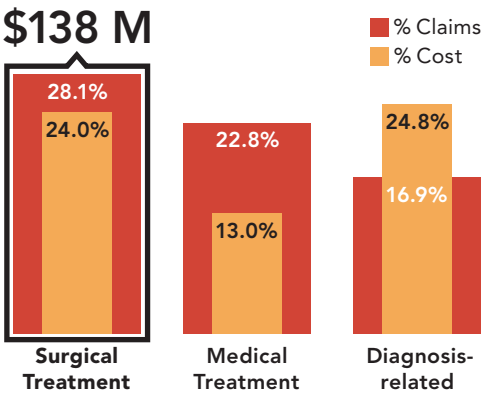
Our analysis of Constellation medical professional liability (MPL) claims* shows that **surgical allegations top the list in occurrence and are second in cost incurred.**

Surgical allegations

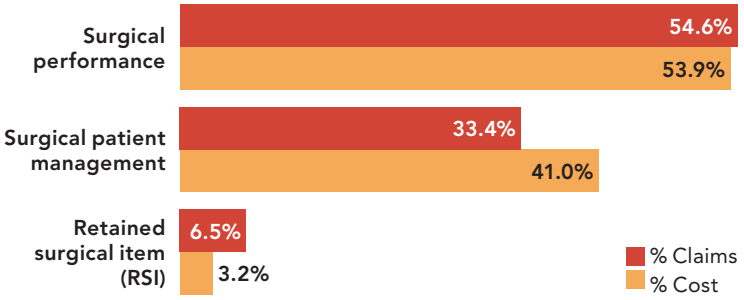
#1 in occurrence **#2** in cost **$138 M** total incurred cost

*Constellation MPL claims asserted from 2010–2017

Allegations triggering all claims



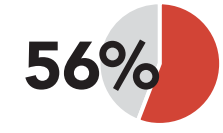
Allegations triggering surgical claims



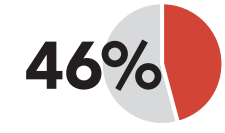
Surgical performance—Occurs in the operating room
Surgical patient management—Steps taken pre-, intra-, and postoperative
Retained surgical item (RSI)—Unintended retention of an item

What is driving surgery claims?

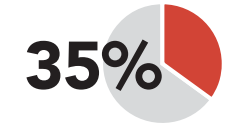
of performance claims involve intraoperative technique including known procedural risks



of management claims involve patient assessment issues



involve musculoskeletal or digestive procedures



involve communication breakdowns

Surgical claim costs

When surgeries go wrong, costs can occur in the form of payment to the injured patient or family, and also in the investigation and defense of a claim. Beyond these monetary costs are stress and lost productivity for clinicians and care teams, reputation damage to the organization and breakdown of patient–surgeon relationships.

Our analysis shows that 28% of surgical claims are closed with indemnity paid, meaning that a payment was made to the injured patient or their family after investigation into the claim determined the standard of care was not met. This percentage is significant, but similar to the 28.9% of all claims that are closed with an indemnity payment. The average indemnity paid on a surgical claim was $297,000.

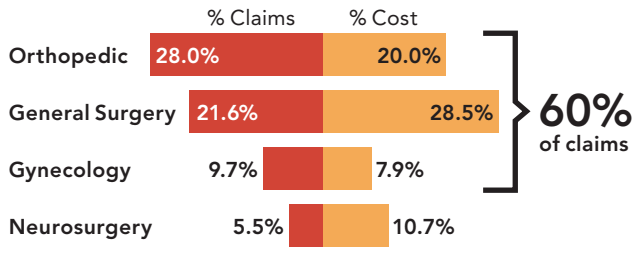
Although the majority of claims closed without an indemnity payment, there were expenses involved in investigating a claim—the average expense of a surgical claim was $47,000. The majority of these surgical claims involved technical skill factors, including known procedural risks that should have been discussed prior to surgery while obtaining informed consent from the patient. Yet patients still file malpractice claims.

Key Questions for Leaders

1. Why aren't surgeons recognizing these known risks and complications intraoperatively or early postoperatively and intervening before serious patient harm occurs?
2. Was the communication about the procedure's alternatives, benefits and risks clear and understandable when obtaining informed consent from the patient?
3. Did the informed consent process include a discussion of postoperative expectations and goal setting?

What specialties are driving claims?

Sixty percent of claims involve clinicians in three clinical specialties: orthopedics, general surgery and gynecology. Neurosurgery claims are notable as well, as they account for a disproportionately large amount of costs.



Where is loss occurring?

Patient harm events that lead to malpractice claims are happening in three key settings: hospital operating rooms, ambulatory or day surgery centers, and clinics.

Top 3 locations of loss

44% Hospital operating rooms

26% Ambulatory or day surgery centers

12% Clinics

Which procedures are involved?

Some common surgical procedures are more likely to lead to claims, including musculoskeletal surgeries involving hips, knees or shoulders; digestive procedures such as laparoscopic gall bladder surgery, sigmoidectomy or laparoscopic appendectomy; spinal surgeries involving intervertebral discs or spinal fusions; and gynecologic procedures including hysterectomies.

Top 4 surgery types involved

23% Musculoskeletal

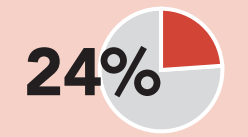
23% Digestive

10% Spinal

9% Gynecologic

What injuries are most cited?

- Puncture/perforation
- Laceration/tear
- Nerve damage
- Infection



are high-severity events including death

Surgery claims are serious

When surgical patient harm occurs, roughly one-fourth (24%) involve high-severity injuries, including death. Common instances of claims include things like sepsis and death following abdominal surgery, or wrong-site spinal surgery resulting in total disability. Nearly three-fourths of claims (72%) involve medium-severity injuries—things like postoperative infection or non-debilitating nerve damage.

What can be done to improve outcomes and limit patient harm?

Clinicians seek to do no harm, but it is inevitable that errors can and will occur. When these events happen despite clear intentions to improve the lives of our patients, there are ways to better manage going forward. Some factors are within our control and can make a significant difference. The following section summarizes the key areas of focus that can help you improve care and limit claims, benefitting your care teams and your organization in myriad ways.

Top 3 Areas of Focus to Improve Your Care and Help Prevent Claims

Clinical analysis of Constellation claims reveals that they are often driven by factors that can be mitigated with patient safety strategies. These three areas of focus can help you improve your systems and processes, better support your care teams and help limit risk to your clinicians and organization.

1. Improve your preoperative decision-making and communication

- ☐ Use clinical decision support tools to assess surgical appropriateness/readiness/risk
- ☐ Improve your informed consent process, including expectation and goal setting

2. Be aware of potential gaps in intraoperative technical skill and recognize potential complications up front

- ☐ Are there experience issues, including outdated technique or inexperience with new procedures?
- ☐ Are there equipment issues, including inexperience with new equipment, operator error or equipment malfunction?
- ☐ Is there failure to recognize complications/known procedural risks during surgery?
- ☐ Is there failure to have or follow procedural checklists?

3. Watch for failures in postoperative judgment and communication

- ☐ Patient assessment and monitoring failures
- ☐ Hierarchical and handoff communication challenges
- ☐ Lack of strong patient safety culture
- ☐ Poor critical thinking skills
- ☐ Postoperative discharge instruction and communication failures

LORI ATKINSON, RN, BSN, CPHRM, CPPS
Content Manager and Patient Safety Expert
Constellation
Lori.Atkinson@ConstellationMutual.com

LIZ LACEY-GOTZ
Common Factors *Editor*
Communications@ConstellationMutual.com

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