When Skill and Technique Fall Short

Surgical performance allegations are the top driver of surgical claims and costs.

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

More than half of surgery claims (55%) involve allegations of surgical performance related to issues with the technical skill or knowledge of technique of the surgeon. More than half of performance claims (56%) originate from patient harm event in hospital operating rooms (ORs), with about one-third (35%) occurring in outpatient surgery center ORs.

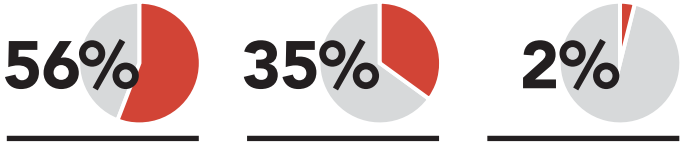
Largely, these claims center on intraoperative technical skill/technique and clinical judgement issues, including patient assessment and selection of the surgical procedure.

Surgical performance allegations

Included in **55%** of surgery claims

Account for **54%** of costs

Where claims are happening



Three C's at work: Culture, critical thinking and communication

Culture can play a significant role in surgical claims. You might not think of culture as connected to performance, but when hierarchical or other negative behaviors are present in a care team, it can easily impact the patient. If team members don't feel they can ask for help or call out a concern, performance can be negatively impacted.

In a healthy culture without hierarchical issues, for example, nurses can double check that the surgeon has privileges and is credentialed for the procedure and equipment involved. They can make sure to say something if they see something that needs addressing. They should feel comfortable—and respected—for speaking up. Leadership also plays a key role in culture by upholding proper credentialing, and holding physicians accountable for ensuring they have the proper training, equipment and staff to proceed.

Critical thinking also plays an important role in preventing surgical patient harm and resultant malpractice claims, especially as the surgeon diagnoses the condition and assesses which procedure is best for the patient. Sometimes an outlier diagnosis or a less invasive procedure is missed as an option. Why? Because it is easy to have an automatic response, especially when you think this is something you've seen before and have the answer. But with critical thinking we stay open and alert so that we can see something we can improve, overcoming the biases that narrow our focus and prevent us from seeing the bigger picture.

Communication issues can also be involved in surgery claims related to technical performance. Most specifically, obtaining informed consent, setting realistic expectations and discussing known procedural risks are critical to getting a patient on board with both the benefits and the risks of their surgery. This can include making sure a patient is aware that their medical history—including existing conditions such as obesity or diabetes—might have an impact on recovery or complications. It's also important to make sure you are communicating in a way, and at an appropriate health literacy level, that the patient clearly understands. Having tools like videos or professional interpreters can help.

Constellation uses claim data to help customers identify key areas of risk in their organization. A hospital may only have one claim of a certain type, but the data can help them see larger trends that might indicate areas of potential risk that need to be addressed. With analysis, it's possible to develop solutions to help mitigate risk in the future—benefiting the organization, their care team and also their patients. Because every patient harm event, and every single resulting claim or lawsuit, is significant.

Diving Deeper into the Data

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

1. **Technical skill issues (93%),** including known procedural risks not recognized during surgery
   - **Experience issues,** including first time doing a procedure, a twist on procedure, not staying current with practice, out-of-date technique or poor learning environment
   - **Equipment issues,** such as settings not maintained or not observed, inexperience with new equipment, user error or other type of equipment malfunction
2. **Clinical judgment issues (45%)** include:
   - **Patient assessment issues,** including failure to use clinical decision support tools to assess surgical appropriateness, readiness and risk
   - **Poor assessment,** poor monitoring, poor decision making, not considering alternatives to surgery, diagnostic focus too narrow
   - **Failure to recognize known risks/complications** intraoperatively or soon postoperatively, lack of situational awareness, not being vulnerable to having made an error during surgery
   - **Failure to have or follow procedural checklists**
   - **Poor critical thinking skills**
3. **Patient behavior factors (25%),** 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.
4. **Communication issues (25%)**
   - **Patient communication**
     - Includes ineffective informed consent process, including expectation and goal setting, especially involving claims with known procedural risks
   - **Team communication**
     - Surgical team not knowing the privileges or credentials of the surgeon
     - Hierarchical structure
     - Poor patient safety culture in team members not speaking up due to unprofessional surgeon behavior, or fear of retaliation.
5. **Documentation (10%)**
   - Surgeon not documenting thought process regarding the selection of procedure, especially consideration of non-surgical alternatives
   - Late operative reports (dictated months after procedure)

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

Surgical Performance Claims Examined

Limited technical experience compounded by late documentation

A 55-year-old woman with a history of a pelvic fracture due to a fall was referred to an orthopedic surgeon after failed cement injections. The orthopedist recommended surgery and placed a four-hole plate into the sacrum with three screws (the three-hole plate he requested was not available at the facility where surgery was performed).

Following surgery, she was noted to have a peripheral nerve injury and the surgeon took her back to surgery. The plate was removed. She continued to have numbness, weakness in dorsiflexion, and she required assistance with activities of daily living.

The experts who reviewed the claim were critical of the orthopedist as he had only done a limited number of these procedures. The operative report was also dictated as being "uncomplicated" and was done three months after the procedure.

Contributing factors:

- Surgical skill/performance
  - Inexperienced in procedure
  - Equipment availability issues
- Communication issues: no disclosure to patient about the plate discrepancy
- Documentation issues
  - Dictated as uncomplicated with no mention of four-hole vs. three-hole plate being used
  - Late dictation of operative report

Poor treatment plan and technique lead to serious postoperative complications

A general surgeon performed a colonoscopy on a patient but stopped the procedure before visualizing the entire colon because he was worried about perforating the colon. He then recommended a total colectomy procedure without discussing other conservative treatments with the patient. The general surgeon encountered a stapler failure during the colectomy procedure and noted "operator error" in his operative note. He then hand-stitched the residual stump area.

Two months after surgery, a CT of the abdomen showed anastomosis clips with dehiscence and abscess. The general surgeon performed fluid drainage on the area. Two months later, a pelvic CT still showed residual abscess and the general surgeon referred the patient to a colorectal surgeon for further surgical treatment.

The experts who reviewed the claim were critical of the colectomy technique used by the general surgeon.

Contributing factors:

- Surgical skill/performance
  - Practicing outside of specialty training
- Communication issues: poor informed consent process in not disclosing alternatives including conservative treatment vs. surgery

Potentially unnecessary surgery causes long hospital stay and long-term disability

A 54-year-old man with complaints of diverticulitis was referred to a colorectal surgeon. The surgeon performed laparoscopic surgery to remove the diseased portion of the bowel but had to convert to an open procedure due to the amount of diseased bowel he encountered. Three days after surgery the patient began running a fever and a CT identified an anastomotic leak. The surgeon took the patient back to the OR and placed multiple drains. The man remained hospitalized for 31 days.

Two months later the patient began vomiting what he thought was stool. He was taken by ambulance to a tertiary center where a surgeon removed more sections of diseased bowel and created a colostomy. One year later, he had surgery to reconnect his bowel. He was out of work and then disabled as a result of this complication.

The patient and his spouse said if they had known about this potential disabling complication, they would not have consented to the procedure. They would have opted for more conservative antibiotic treatment first.

Contributing factors:

- Surgical skill/performance
  - Known procedural risks not disclosed
- Clinical judgment failures
  - Patient assessment
  - Selection of surgery
- Communication with patient
  - Poor informed consent

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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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