Malpractice Claims Involving Surgeons

by Kathy Dwyer

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Surgeons, who represent 14 percent of CRICO-insured[1] physicians, are named in 31 percent of the CRICO malpractice cases asserted over the past five years. From January 2002-September 2007, 407 surgery-related claims[2] were filed naming 470 physicians, and accounting for nearly one-third of CRICO's total incurred losses.[3] Although a vast majority of the claims were resolved without payment, the emotional toll for patients and providers can be enormous. The average indemnity payment for those cases that *were* closed with payment was $676,000, 28 cases closed with payment exceeding $1 million (see Page 4).

Plaintiff patients commonly allege that an unexpected and preventable outcome (i.e., injury, complication, or non-resolution of their pre-operative condition) was caused by technical, cognitive, or communication errors that (often) occurred before or after the operation, as well as in the operating room (OR) during surgery. The surgical complications in the cases include:

- collateral damage to adjacent organs (e.g., dividing a ureter);
- significant postoperative hemorrhage;
- unrecognized injuries (e.g., spleen or bowel injury);
- failures of surgical anastomoses;
- retained foreign bodies;
- wrong site surgery; and
- other unplanned returns to the OR.

Technical error was a prevalent factor in 58 percent of the cases, followed by clinical judgment/decision making errors (54 percent), and communication breakdowns (43 percent).[4] Deeper analysis of the CRICO cases identifies persistent problems with the supporting systems in and out of the OR, including wrong site surgery; inadequate communication among clinicians; failure of staff to follow procedures; less than ideal team performance; fumbled handoffs; and supervision gaps.

Communication Factors

From the research, focus groups, demonstration projects, and the patient safety initiatives that CRICO has funded in surgery over the last few years, it has become clear that a surgeon's communication style—directly and indirectly—impacts patient safety. While surgeons cannot control the entire process, they can have great influence in bringing out the best in their colleagues, especially in a crisis. Suboptimal communication is a factor in a significant number of surgery-related claims. Breakdowns in surgeon-patient interactions prior to surgery, team communication in the OR, and post-op supervision are all exposed when the outcome is unexpected and subject to investigation. In many cases, poor communication exacerbates technical or clinical judgment errors that might be recoverable given a better exchange of critical patient information (see *A Good Day in the OR*, page 9).

Consent

An adverse surgical outcome that is also unexpected is more likely to motivate litigation than if the patient has been adequately prepared for it. Upon examination, one out of every five CRICO surgical cases reveals a significant issue related to informed consent, including the decision to undergo the procedure, the risk-benefit equation, what the surgeon plans to do, expectations for post-op quality of life, and a reasonable comprehension of potential complications. Inadequate informed consent manifests itself in several ways, including:

- the patient is not told of alternative treatments;
- the medical record does not reflect the conservative treatments tried and the results,
- the surgeon fails to realistically represent the risks as well as the likely outcome of the procedure,
- a lack of preparing the patient for what is to come (i.e., the patient is completely surprised),
- in explaining the potential risks of a procedure, the surgeon fails to put him or herself "in the shoes" of the patient, and
- the informed consent is obtained on the day of surgery when there is no time to reflect on the course of treatment.

Table 1

CRICO-insured Surgeons by Specialty[a]

14 percent of all CRICO-insured MDs

In 2006, CRICO-insured institutions performed 79,400 inpatient surgeries, 149,300 outpatient surgeries.

General Surgery	381
Orthopedic Surgery	195
Ophthalmology	153
Gynecology	121
ENT	109
Urology	66
Neurosurgery	64
Plastic Surgery	57
Cardiac Surgery	51
Thoracic Surgery	40
Vascular Surgery	34
Oncology Surgery	33
Oral Surgery	31
Podiatry	26
Other surgical specialties	14
Total	**1,375**

a As of December 2006

Table 2

CRICO Professional Liability Claims

Cases Asserted 2002–Sept. 2007	All CRICO	Surgery-related[a]
Total cases	1,319	407
Cases with high-severity injury[b]	597	154
Average indemnity incurred	$671,000	$628,000
Cases Closed 2002–Sept. 2007	**All CRICO**	**Surgery-related**
Cases	1,344	421
Cases closed with indemnity payment	31%	29%
Total indemnity payment	$252M	$81M
Average indemnity payment	$605,000	$676,000
Cases closed with indemnity payment >$1M	88 (6.7%)	28 (6.9%)

a Claims and suits in which a surgical specialty was responsible for the patient at the time of the alleged event.
b Permanent significant, major, or grave injury, and death.

Table 3
CRICO Surgery-related Claims
2002–Sept. 2007

Physician Defendants	N=470
Staff	390
Fellow	15
Resident	65
Non-physician Defendants	**N=313**
Organization	267
Nurse	33
Physician Assistant	3
Other	10
Top Responsible Services	**N=407**
Orthopedics	95
General Surgery	32
Gynecology	46
Neurosurgery	45
Plastic Surgery	27
Cardiac Surgery	21
Otolaryngology	18
Urology Surgery	18
Top Locations	**N=407**
Operating room	223
Physician's office/clinic	79
Ambulatory surgery	56
Offsite	12
Top Risk Management Issues	**N=1,018**
Technical skill	236
Clinical judgment	219
Communication	173
Top Case Types	**N=407**
Inadequate informed consent	79 (19%)
Wrong site surgery	67 (16%)
Retained foreign body	39 (9%)

Provider-to-Provider Communication

Surgery-related malpractice cases that involve communication breakdowns between providers often germinate from one party either a) having the mindset *"I didn't think you needed to know that,"* or b) failing to stress his or her most important concern (e.g., potential for blood loss). Such assumptions—that the information was not needed by the other members of the patient's care team—unnecessarily elevate a moderate risk to a potential crisis. On the other hand, the use of such tools as team timeouts/briefings, checklists, and sign outs can help systematize better team communication.

Supervision

Residents and fellows account for 17 percent of the physicians named in the surgical claims. Those cases are predominately related to situations in which a post-op patient's complication(s) were recognized or acted upon too late to prevent irreversible damage. Several of the cases depict residents getting into trouble and not communicating with the team—not even the attending—about the problem or not knowing when to ask for help. Inadequate communication in the other direction—e.g., when the attending surgeon does not share key information with the postoperative team caring for the patient is also noted in the surgical claims (see Regenbogen, page 12).

Lessons

Analysis of CRICO's surgery-related malpractice claims shows that improved safety for surgery patients necessitates attention to technical, teamwork, and communication skills employed from the initial patient visit through the post-op discharge process. Physicians, nurses, and technicians—regardless of status or specialty—should all consider themselves essential to providing a safe environment and optimal outcome (see Mandell, page 7).

Helping the patient have realistic expectations is critical (see Riley, page 16). Patients who are adequately informed about and prepared for the very real risks of complications are less likely to seek retribution when they do, unfortunately, occur. Once the patient is in the OR, surgeons can and should help create an environment that fosters teamwork via briefings, timeouts, and any other opportunity to connect with colleagues. Surgeons who have framed a good rapport within the clinical setting greatly reduce the risk of critical information being lost due to misbegotten assumptions. Likewise, surgeons who strive for a high level of individual professionalism (see Whittemore, page 22) properly set the stage for highly reliable team performance.

Certainly, some adverse surgical events can be avoided with better technical training and proficiency (see Jones, page 18). But, no matter how qualified or experienced the surgeon, many technical "errors" are virtually unavoidable: known complications of complex procedures, complex anatomy, or complex co-morbidities. What is avoidable, is failing to promptly recognize and skillfully manage those complications. Surgery teams with a common understanding of how they will handle the unexpected are less likely to be caught unprepared in the face of an unforeseen complication.

Finally, when errors do occur and lead to an adverse and unexpected outcome, surgeons cannot abandon their patients (see Shapiro, page 20). Disclosing facts as they become known, extending compassion and being available to the patients, and seeking help for their own emotional disruption, are necessary steps surgeons must take in beginning to heal the break in trust.

Using Malpractice Data to Support the Need for Change

Research has shown that the adverse events that lead to malpractice claims are a (relatively small) subset of all adverse medical events.[5] Nevertheless, the overall occurrence is infrequent: each year, CRICO-insured surgeons perform more than 225,000 (inpatient and outpatient) surgical procedures; each year, approximately 70 patients file malpractice claims or suits. The frequency of surgical malpractice cases may be infinitesimal, but no one considers any one of them insignificant; the consequences for the patients, their families, and the surgeons

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and other clinicians are often devastating. Every avoidable adverse event is worthy of some degree of investigation, comprehension, and action to prevent recurrence. Across the Harvard-affiliated hospitals, the surgery departments have been working—initially independently, and now in collaboration (see Augello, page 14)—to reduce the risk of adverse events. This innovative and important work will drive changes in how surgeons are trained, how they communicate, and how they see themselves as partners in patient safety. ■

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Notes

1 Professional liability insurance coverage for MIT and Harvard-affiliated medical institutions is provided by Controlled Risk Insurance Company of Vermont, Inc. (A Risk Retention Group) and Controlled Risk Insurance Company, Ltd (CRICO).

2 Based on claims and suits in which a surgical specialty was responsible for the patient at the time of the alleged event.

3 Incurred losses aggregate reserves on open cases, payments on closed cases, and expenses.

4 A single case may be assigned multiple risk management issues, thus the totals exceed 100 percent.

5 Committee on Quality of Health Care in America. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press, 1999.

Surgery-related Cases Asserted 1998-2007 that Closed with Payment ≥ $1,000,000

Event Year	Description
1993	36-year-old male suffered multiple complications after gastric by-pass, resulting in total gastrectomy and need for enteral feedings
1994	30-year-old male suffered an intracranial hemorrhage during a brain biopsy (plaintiff alleged inadequate pre-operative evaluation)
1996	16-year-old male sustained spinal cord injury during rod placement for scoliosis, resulting in paraplegia
1996	47-year-old female died following a lumbar diskectomy due to a torn iliac vein during procedure (attending surgeon was not in attendance for much of the procedure)
1996	32-year-old male, who developed respiratory complications after a bowel resection, alleged improper management (delay in intubation)
1996	Three-year-old female had extensive deep invasion and spread of retinoblastoma after undergoing eye enucleation (no other treatment offered or consultations obtained)
1996	45-year-old male alleged a delayed diagnosis of invasive nasopharyngeal squamous cell carcinoma
1996	Two-year-old female suffered loss of vision due to an alleged delay in diagnosis and treatment of bilateral subdural hematomas sustained after falling at home
1996	31-year-old female alleged that failure to diagnose a brain tumor led to her loss of vision
1997	50-year-old female's posterior ligament was punctured during spinal surgery, resulting in paraplegia
1997	Two-year-old female sustained anoxic encephalopathy due to cardiovascular collapse during surgery for an obstructed bowel (alleged failure to recognize severity of SBO symptoms resulted in surgical delay and brain damage)
1998	35-year-old deaf male developed respiratory distress post IV sedation (alleged inadequate informed consent, i.e., no interpreter)
1998	51-year-old female undergoing an elective resection of a large hepatic cyst died as a result of severe bleeding due to ligation of the IVC (inadequate informed consent was alleged)
1998	48-year-old male sustained brain damage due to an air embolism after SG catheter disconnected during patient transfer
1998	44-year-old male died after post-op communication between fellow and attending surgeon was delayed
1998	17-year-old male sustained post-operative brain damage allegedly due to to poor communication among providers and a lack of coordination of care
1999	37-year-old male sustained brain damage during repair of AVM due to the adhesive used in procedure (radiologist who was aware of complications from adhesive, used a backdated letter from manufacturer allowing patient into the study)
1999	28-year-old female suffered neurologic deficits (double vision, slurred speech, and gait problems) after having electrodes implanted into her brain
1999	33-year-old male suffered quadraparesis following anterior cervical diskectomy due to a dural leak
1999	48-year-old male sustained a dural tear and partial avulsion of nerve root along with large blood loss during diskectomy, resulting in multiple surgeries and neurologic deficits
1999	One-month-old (premature) male was rendered blind after an alleged failure to timely diagnose and treat retinopathy (coordination of care was a contributing factor)
2000	48-year-old obese female with known sleep apnea went into respiratory arrest and died after a vitrectomy (her estate alleged an inadequate history and physical, miscommunication among providers, and errant selection/management of pain medications)
2000	40-year-old female underwent wrong-site surgery and acquired Addison's disease
2000	32-year-old female sustained lower extremity paralysis/paraplegia from spinal cord damage post excision of a pelvic mass
2000	One-year-old female (with hydocephalus) died when surgery to repair a failing shunt was delayed because the surgeon could not be reached
2000	69-year-old female died after sustaining a pulmonary artery puncture during AAA re-repair (no communication of the complication was noted to patient or other providers)
2000	31-year-old female required multiple surgeries following revision of gastric bypass (surgeon inexperience with procedure seen as contributing factor)
2001	24-year-old male suffered multiple neurologic impairments post spinal fusion, requiring re-exploration and removal of bony fragments
2002	45-year-old male complained of new pain due to malposition of surgical screw (surgeon left the OR suite during procedure and never informed patient of incident)