THE DOCTORS COMPANY

SURGERY

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June, 2015

DISCLOSURE STATEMENT

The Doctors Company would like to disclose the presenter(s) and author(s) who are in a position to control the content of this activity have reported no relevant financial relationships with commercial interests.

DARRELL RANUM

Biography

Darrell Ranum is licensed to practice law in Ohio. He has more than 25 years of experience in healthcare, professional liability, risk management and patient safety.

As vice president, he supervises health care professionals who provide risk consulting services and education to hospitals, physician groups, and other organizations insured by The Doctors Company.

DARRELL RANUM

Biography (continued)

Mr. Ranum manages studies of medical malpractice claims and suits for the Company. The purpose is to identify and communicate system failures that result in patient harm. He is a frequent speaker and author on this research and related topics.

Mr. Ranum serves as vice president for legislation on the Board of the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).

STUDY APPROACH

STUDY PLAN

- Divided study into three phases
  - Consulting and pre-operative care
  - Intra-operative care
  - Post-operative care
- Study includes claims closed from 2007-2014 (2nd Qtr.)
  - Total number of claims in the database = 19,102
  - Total number of claims for surgical services = 7,791 (41%)

SURGICAL SERVICES

- Orthopedics 26%
- Plastic surgery 18%
- General surgery 14%
- Gynecology 11%
- Neurosurgery 6%
- Otolaryngology 6%
- Urology surgery 4%

Podiatry 2%

Oral surgery 2%

Cardiac surgery 2%

Thoracic surgery 1%

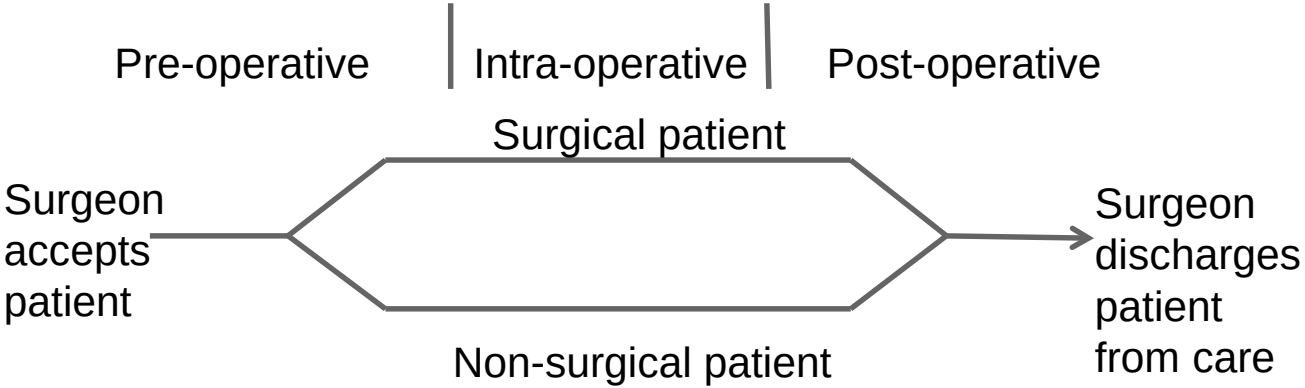
Vascular surgery 1%

Bariatric surgery 1%

Hand surgery 1%

Six other surgical service areas made up the remaining 5%

SURGICAL SERVICES



INJURIES TO SURGICAL PATIENTS

- Need for surgery 26%
- Pain 18%
- Infection 12%
- Emotional trauma 12%
- Death 11%
- Mobility dysfunction 10%
- Nerve Damage 8%

Puncture or perforation 7%

Scarring 7%

Sensory impaired 5%

Foreign body 4%

Hospitalization 4%

Hemorrhage 4%

Laceration or tear 4%

Patients may suffer more than one injury.

PRE-OPERATIVE CARE

PRE-OPERATIVE ALLEGATIONS

- Diagnoses-related issues 79%
- Failure to treat or delay in treatment 6%
- Failure to obtain consent 4%
- Wrong or unnecessary treatment or procedure 1%

PRE-OPERATIVE CONTRIBUTING FACTORS

- Patient assessments issues 74%
  - Inadequate assessment – failure or delay ordering diagnostic tests
  - Narrow diagnostic focus – failure to establish a differential diagnosis
  - Misinterpretation of diagnostic studies (x-rays, slides, etc.)
  - Over reliance on negative findings on patients with continued symptoms or complaints

PRE-OPERATIVE CONTRIBUTING FACTORS

- Communication between patient/family and providers 21%
  - Inadequate informed consent for treatment options
  - Inadequate informed consent for surgical procedures
  - Language barrier
- Insufficient or lack of documentation 15%
  - Informed consent
  - Clinical findings or rationale

PRE-OPERATIVE CONTRIBUTING FACTORS

- Failure or delay obtaining consult or referral 11%
- Failure or delay reporting findings or revised findings 11%
  - Clinician did not receive results – filed before clinician review
  - Patient did nor receive results – no report or wrong report

PROBLEMS THAT RESULTED FROM CARE PROVIDED BEFORE SURGICAL INTERVENTIONS

- Untreated malignancies
- Untreated fractures
- Unrealistic patient expectations

INTRA-OPERATIVE CARE

INTRA-OPERATIVE CARE ALLEGATIONS

- Improper performance of surgery 69%
- Improper management of surgical patient 12%
- Retained foreign body – surgical 5%

INTRA-OPERATIVE CARE FACTORS THAT CONTRIBUTED TO PATIENT INJURY

- Technical performance 50%
  - The injury was known to the patient as a risk of the procedure (40%)
  - Poor technique – wrong patient, incorrect body site, misidentification of an anatomical structure, inexperience with the procedure, break in sterile technique (10%)

INTRA-OPERATIVE CARE FACTORS THAT CONTRIBUTED TO PATIENT INJURY

- Selection and management of therapy 13%
  - Selection of surgical procedures (12%)
  - Selection of medication (1%)
- Retained foreign body 4%

POST-OPERATIVE RISKS

POST-OPERATIVE ALLEGATIONS

- Diagnosis-related issues 28%
  - Complications of surgery (hemorrhage, tissue necrosis, bowel leaks, infections, pulmonary embolism, malunion or non-union of fractures, opiate poisoning, incorrect dosing with anticoagulants)
  - Comorbidities (sleep apnea, diabetes, respiratory insufficiency)
- Improper management of treatment course 14%
- Improper medication management 4%

POST-OPERATIVE FACTORS THAT CONTRIBUTED TO PATIENT INJURY

- Patient assessment issues 33%
  - Failure or delay ordering diagnostic tests
  - Failure to establish a differential diagnosis
  - Failure to consider available clinical information or address abnormal findings
- Patient factors 30%
  - Seek other providers due to dissatisfaction (20%)
  - Patient did not adhere to medication or treatment plan (10%)

POST-OPERATIVE FACTORS THAT CONTRIBUTED TO PATIENT INJURY

- Selection and management of therapy 22%
  - Regarding surgical or other invasive procedures
  - Medical treatment
- Communication among providers 17%
  - Regarding patient's condition

FINDINGS

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- Diagnosis-related issues continue to be challenging
  - Incorrect diagnoses
  - Inadequate assessments
  - In the pre-op phase or post-op phase
- System breakdowns
  - Ordering tests, receiving test results, evaluating the implications for surgery, consultation with other specialists

FINDINGS

- Operations on the incorrect patient, body site, anatomical structure
- Retained foreign bodies
- Break in sterile field
- Complications unrecognized
  - Burns, punctures, lacerations

FINDINGS

- Conditions not recognized before surgery such as clotting abnormalities, stomach contents, electrolyte imbalance, or obstructive sleep apnea
- Recognizing complications of surgery not always timely
  - Hemorrhage, compartment syndrome, infection, organ perforations, spinal epidural abscesses, respiratory distress

FINDINGS

- Patients don’t understand the risks of their surgery. 40% of claims were filed because a patient suffered an injury that was a risk that was known to the patient prior to surgery.
- Twenty percent of patients seek other providers due to dissatisfaction with their first provider (20%).

FINDINGS

- Managing patients post-operatively
  - DVT and PE risk and prophylaxis
  - Medication management and risk of respiratory depression
- Patients suffered extended hospitalizations, lost limbs, were paralyzed, suffered brain damage, or died when symptoms were not recognized, communicated, or addressed in time.

WHY?

WHY DO PATIENTS CONTINUE TO SUFFER INJURIES FROM SURGICAL CARE?

- We know the vulnerabilities – where our systems have failed
- We have evidence of systems improvements that reduce errors and injuries
  - Bundles, checklists, time-outs, protocols, teamwork, communication techniques, simulations of low frequency and high severity events
- Training is available
- In many situations, we know what steps are needed to improve

WHAT HINDERS US FROM MOVING FORWARD?

- Fear of change?
- Resistance to adopting new approaches?
- Anger at loss of control?
- Comfort and efficiency of our old ways?
- Doubt that new processes are better?
- Lack of determination to confront those who refuse to adopt process improvements?

CROSS EXAMINATION

CROSS EXAMINATION

What should have been done differently to ensure a better outcome?

- Every step on the process from the time a patient is accepted until discharged from the practice, has risks.
- Systems and processes need to function effectively
- We cannot engineer all weaknesses out of these systems
  - We need people to speak up when a system fails to produce the result
  - The culture needs to create a safe environment even if the person is wrong in their perceptions of system failure

CROSS EXAMINATION

Examples:

1. Three large health systems announced a ban on low volume procedures
2. Gallup announced study findings on the benefits of pre-surgery education
   – May 20, 2015
3. JAMA article summarized, “Association Between Implementation of a Medical Team Training Program and Surgery Mortality.
   – VHA Medical team training program was associated with lower surgical mortality

THANK YOU

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reward the practice of good medicine.