An Analysis of Neurosurgery Closed Claims

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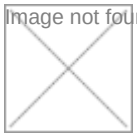
A review of Neurosurgery closed claims from 2004 – 2016, where a loss was paid on behalf of an insured, reveals that there were 3 basic areas (excluding errors in medical judgment and/or technical performance) that contributed to the indefensibility of the claims. These topics are illustrated in the graph below:



DOCUMENTATION ISSUES: Documentation is one of the most important patient care and risk management skills a healthcare professional can develop. Inadequate documentation can negatively impact your ability to defend the care provided to a patient.

As the graph above illustrates, documentation issues were a factor in 60% of claims paid in neurosurgery. Of those, 57% involved inadequate documentation due to such things as:

- incomplete pre-op work-up and patient history
- incomplete or no documentation of patient phone calls
- lack of sufficient information to support rationale for treatment decisions
- sparse or lacking documentation of information given during the informed consent process
- non-specific or incomplete discharge instructions.

A specific case example involved a patient who presented to the ED with complaints of neck pain the day after fainting and falling at her home. A CT and X-rays of the cervical spine were ordered which revealed a C5-C6 fracture. The patient was admitted and a neurosurgeon was consulted who ordered a MRI which, in addition to the fracture, revealed a moderate sized epidural hematoma beneath the C5 and C6 lamina. The patient was discharged the next day since her pain level had improved, she was neurologically intact, was ambulating, had full strength and had no complaints of radiating pain, numbness or tingling. The written discharge instruction advised the patient to wear a neck collar at all times and to follow up with the neurosurgeon in 6 weeks. Although the neurosurgeon would later testify he also instructed the patient to return to the ED immediately should she experience worsening pain, numbness or weakness, he did not document such in the discharge instructions. The patient returned 2 days later with complaints of weakness in her right leg and hand and having a “funny feeling.” An MRI revealed a significantly larger hematoma that was compressing the cord. The hematoma

was evacuated, but the patient was left with permanent neurological deficit following a lengthy course of rehabilitation. The patient filed suit, alleging failure to timely perform surgery to evacuate the hematoma and failure to provide specific discharge information. While the neurosurgeon's decision to discharge the patient following her initial presentation was defensible given the apparent stability of the fracture, the lack of documentation as to his specific instructions and warnings that would warrant an immediate return to the ED created a swearing match and hampered the defense of the case.

Untimely entries were also a problem in several cases reviewed. Operative notes and discharge summaries dictated weeks, and on occasion, months after the fact often appear self-serving and call into question the integrity of the entire record.

SYSTEMS ISSUES: Effective systems and processes serve to reduce human error that may lead to patient harm. In the cases reviewed, 35% included a systems breakdown, the majority of which (55%), involved wrong site surgery. Examples of factors that led to wrong-site procedures include:

- Reliance on improper site verification by the patient
- Entry of the wrong level into surgeon's mobile device
- Failure to refer to intraoperative studies which contradicted erroneous documentation of the operative site contained in the Consent and Pre-Op Verification forms
- Reliance on a substandard location x-ray
- Failure to confirm the correct level radiographically

Often times, the initial error was compounded by the failure of the surgeon to timely review post-op studies which would have led to earlier recognition and corrective surgery. However, when the wrong site was discovered either intraoperatively or immediately postop, and patients were advised of the error forthrightly and promptly, settlement amounts were typically reasonable.

Other systems errors involved retained foreign objects. One case involved a 61-year-old patient who underwent a decompressive laminectomy. Following the procedure, the sponge count was incorrect so the surgeon ordered a lateral x-ray that he read as negative for retained objects, which led to the conclusion that the nurse had miscounted. Subsequently, the film was over-read by a radiologist who observed the sponge. The radiologist's report was filed in the surgeon's office without his review. The patient presented to the office several times over the next few months complaining of pain but the surgeon did not refer to the report in his file. Finally, at one of the visits, the physician noticed a palpable mass on the lower spine and a repeat lumbar spine film revealed the sponge.

Failure to follow up on abnormal test results was likewise a recurrent theme in the cases reviewed. The typical situation is illustrated by the case involving a patient who was discharged post operatively without any action being taken on abnormal results from an

intra operative culture. He developed a spinal abscess requiring surgery. In another case, a patient was admitted with head trauma. An MRI revealed a possible berry aneurysm and the radiologist suggested angiography. The surgeon did not see the report. The surgeon's LPN dictated the discharge summary but failed to include the MRI findings. Six weeks later, EMS transported the patient to the hospital in critical condition with a ruptured aneurysm.

COMMUNICATION ISSUES: Effective communication is essential in establishing trust and building good patient rapport, which in turn leads to better patient compliance. Of the cases reviewed, 32% involved communication breakdowns. Of those, 75% involved a breakdown in communication between the physician and patient. Common examples include:

- Insufficient patient counseling: Failure to educate regarding the impact of smoking on surgical healing
- Inadequate discharge instructions: Failure to instruct as to what post-op symptoms to look for and when to notify the physician
- Lack of informed consent: Failure to review pertinent risks, benefits and alternatives to the proposed procedure, and to ensure patient's questions are answered

LESSONS LEARNED:

- Document timely and completely - including history, pre-op workup, instructions, telephone calls, the rationale for actions that may not be self-evident and post-op instructions and warnings. Be very clear about which symptoms require immediate physician notification or follow-up care at an emergency department.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits and alternatives. Doing so not only discharges your legal and ethical obligation to provide patients with sufficient information with which to make an educated election about the course of their medical care, but may help create realistic expectations on the patient's part as to the outcome of treatment. Be careful not to educate above a patient's comprehension level. Be sure the details of all discussions with patients are documented in your office record rather than relying on hospital consent forms that are not procedure specific and may not capture all details of the conversation.
- Provide procedure-specific written postoperative instructions to decrease the possibility of non-compliance and reduce the number of callbacks from patients and family who may not remember your verbal instructions.
- Use the Universal Protocol designed to prevent wrong patient/site/procedure surgeries by marking the surgical site appropriately with the patient/representative prior to surgery and use a time out to review relevant aspects of the procedure with the surgical team and to ensure verification and reconciliation of patient information prior to starting the surgical procedure.
- Have all available films and studies that support the planned procedure on hand in the OR.

- When encountering an inaccurate sponge/instrument count, thoroughly review the x-rays and seek radiology assistance if needed.
- Make it your policy to follow-up on all radiology over-reads.
- Have a mechanism in place that prevents labs and radiology reports from being filed or scanned into the EMR prior to your review and sign off.
- In the event of a medical error, have a frank discussion with the patient and family including a description of the events, without either accepting or placing blame, along with a sincere acknowledgment of regret for the unfortunate nature of the event. Call an SVMIC Claims Attorney to discuss – 800.342.2239.
- The operating surgeon is responsible for the content of the discharge summary. It is important to be aware of state and hospital rules, regulations or opinions that may prohibit delegating this duty.
