An Analysis of Otorhinolaryngology Closed Claims

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A review of paid otorhinolaryngology claims from 2009-2016 revealed that inappropriate surgical technique/treatment and failure to diagnose were the most common allegations. Often times the failure to timely diagnose was not the result of a lack of clinical judgment or medical expertise, but rather, was the result of the failure to follow up on a test result or missed appointment or the mishandling of a telephone message. Consistent systems and processes are crucial to ensure continuity of care.

Inadequate documentation was noted to be present in over half of the cases reviewed and was the most prevalent factor contributing to the inability to defend against allegations of inappropriate technique/treatment. One example involved a 59 year old obese patient with an extensive medical and surgical history who underwent a colon resection for adenocarcinoma. The insured ENT physician was consulted post-operatively and agreed a tracheostomy was advisable in the face of long-term intubation. The patient's hospital course was remarkable for sepsis, respiratory compromise with subglottic stenosis, pulmonary edema, atelectasis with pleural effusions and repeated failed extubation attempts. The patient was discharged home with the tracheostomy tube in place. Insured removed the tube in his office 3 weeks later. The patient arrested and died at home several hours after the removal. The lawsuit alleged negligent removal of the tracheostomy tube. Complicating the defense of this allegation was the fact that the insured ENT had virtually no documentation to support his assertion that he did a proper assessment and evaluation of the patient's respiratory status before and after removal of the tracheostomy tube. The fact that the patient died shortly after extubation, along with numerous notes in the hospital record by the treating pulmonologist that the physician removing the tracheostomy tube should carefully evaluate the subglottic area prior to tube removal, led to the settlement of the case.

In another case, a 5 year old patient, with a history of asthma, underwent an uneventful adenotonsillectomy with ventilation tubes. Shortly after being transferred from recovery to the floor, the patient developed an adenoid bleed. The insured ENT was called and elected to treat the bleeding with Neosynephrine and a FloSeal injection. Shortly thereafter the patient began coughing up large amounts of blood and clots and was returned to the

operating room where the bleeding was controlled. However, the child developed respiratory symptoms requiring hospitalization for several weeks. The plaintiffs asserted that the ENT was negligent in opting to treat the post op bleeding with the Neosynephrine and FloSeal rather than proceeding immediately with surgical intervention. They argued that the patient aspirated blood, which caused the prolonged respiratory problems. The defendant physician argued that such treatment was appropriate and, in fact, the bleeding did stop following the initial treatment and that the patient's respiratory issues were most likely secondary to exacerbation of asthma rather than the bleeding. Unfortunately, there was no documentation to support his assertion that he (1) examined the patient to determine the source of the bleeding and (2) confirmed that the bleeding had stopped following administration of the Neosynephrine and FloSeal. Without documentation to corroborate the physician's assertions, the plaintiffs were persuasive in arguing that the patient, in fact, continued to bleed following application of the Neosynephrine and FloSeal and therefore aspirated the blood due to the nasal occlusion with Floseal.

Communication breakdowns likewise played a part in the initiation of a number of the claims reviewed as well as the indefensibility. Problems with communication were identified in 28% of the claims reviewed, nearly all of which involved direct physician to patient breakdowns. The failure of the physician to discuss material and significant risks associated with the procedure, as well as expected outcomes, most often led to unrealistic expectations on the part of the patient which, in turn, resulted in frustration and dissatisfaction in the face of a complication. Further, the failure to document the process when complications did occur, provided the opportunity for the plaintiffs to contend that they did not receive the relevant and required information needed to make an informed treatment decision, and, if they had, would have sought a more conservative course or a second opinion. Specifically, lack of informed consent was alleged when a patient suffered a cribiform plate injury during an endoscopic nasal polypectomy as well as when another patient suffered injury to the optic nerve during endoscopic sinus surgery, resulting in total blindness in one eye.

Surgical burns were the cause of a number of claims reviewed. Several cases involved bovie burns during tonsillectomies. One case involved ChloroPrep solution, which was inadvertently splashed into the patient's eye during surgery for tumor removal which caused a corneal burn and scarring.

Lessons Learned:

- To promote continuity of care, implement a system to ensure abnormal test results are clearly flagged for follow-up at subsequent visits.
- Ensure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it's important enough for staff to track and for providers to personally review results.
- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected time frame.

- There should be an established system for tracking patients who miss follow-up appointments. If a patient misses or cancels a follow-up appointment, it should be documented and investigated. Appropriate efforts should be made to contact the patient and re-schedule the appointment in situations where the patient may suffer if treatment is delayed or where the treatment or medication must be closely monitored.
- Review the results of all tests ordered pre-operatively to ensure any abnormalities receive proper attention and follow-up.
- Document completely – including history, instructions and telephone calls as well as the rationale for actions that may not be self-evident. Such documentation not only enhances patient care, but bolsters your credibility if you are called upon to defend such care.
- Complete documentation within 24-48 hours of the office visit or procedure. Late completion of notes puts you and your colleagues at risk. Memory interferes with accuracy and efforts to "catch up" often lead to incomplete documentation. Any intervening adverse event prior to completion of notes makes late documentation appear self-serving.
- Clearly communicate with patients when providing medical advice over the telephone. Use the teach back method to ensure an understanding of the information relayed. At a minimum, the following types of phone calls should always be documented in the medical record: when test results are reported, when the patient is advised to return to the office or go to the emergency room, and patient requests for medical advice or prescription refills.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, expected outcome, possibility of an additional or different procedure if indicated, 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 as to the outcome of treatment. Be careful not to educate above the 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, which are not procedure specific and may not capture all details of the conversation.

- Provide clear, detailed, understandable, procedure-specific written postoperative instructions to patients. Patients who have a clear understanding of what signs and symptoms to watch for, how medication should be administered and when to make follow-up appointments are less likely to be readmitted or visit the emergency department.
- Ensure that the entire surgical team is aware of and follows surgical burn safety procedures and protocols. During the surgical time out, communicate with the team about fire and burn risks and the planned course of action in the event of an incident.
- Electrosurgical equipment should be evaluated for damage (e.g. insulation, cables, connectors, return plates) and proper working order confirmed prior to the start of surgery. When not in use, electrosurgical equipment should be placed in a holster

and not on the patient or surgical drapes.