



ACS Closed Claims Study
reveals

CRITICAL FAILURES TO COMMUNICATE

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Hospital chart reviews and root cause analysis of adverse events have indicated that communication is extremely important to quality care, so much that the Accreditation Council for Graduate Medical Education (ACGME) includes interpersonal and communication skills as one of the six core competencies. Claims analysts for liability insurance companies have made similar observations from their reviews of closed claims files. Among the claims reviewers' alarming findings of a closed claims study recently conducted by the American College of Surgeons, 90 of 460 claims (19.8%) were filed largely, if not entirely, because of failures in communication.

This report will share the findings of these 90 claims from the Closed Claims Study relevant to the impact of communication on patient safety and liability. If data and dogma specifically related to issues of communication from the past left us as surgeons nonplussed, that should no longer be the case.

The Closed Claims Study

The ACS Closed Claims Study represents the first of its kind; the relevance to surgeons is maximized because general surgeons from among our ranks designed the standardized data collection form, collected the data from claims pertaining only to general surgeons, and dictated the narrative reviews. Whereas another excellent current closed claims study has focused on the very important subject of systems of care and errors,* the ACS study focuses in tandem on the equal importance of surgeons at the point of service and errors, including communication failures.

The ACS Closed Claims Study was conducted under the guidance of the American College of Surgeons' Patient Safety and Professional Liability Committee. Between April 2004 and February 2006, 40 Fellows of the College conducted reviews of 460 liability claims, a claim in this instance referring to a closed claim against a general surgeon, meaning one that had run its course. All claims are recent, having closed

*Rogers SO Jr, Gawande AA, Kwaan M, et al. Analysis of surgical errors in closed malpractice claims at four liability insurers. *Surgery*. 2006;140(1):25-33.

during 2003 and 2004. Data were collected from five different liability insurance companies with a nationwide distribution. The data have been electronically tabulated at the University of Washington (Seattle) by professionals in the anesthesiology department who have become experts in the field by virtue of their involvement in the American Society of Anesthesiologists' Closed Claims Study since 1984.

Communication failures

Problems stemming from failures in communication occurred predominantly with patients and/or families (36 claims), nurses (19 claims), laboratory personnel (1 claim), and physicians (35 claims). Problems arose from both the failure to listen to or solicit information (47 claims) and the failure to convey information (46 claims). In regard to listening, reviews indicated that defendant-surgeons heard selectively, weighing input in favor of the best scenario. This led to inertia and errors of omission. As an example, a patient in the recovery room after a vascular procedure was reported to have no foot pulses with pain, pallor, and coolness on the left. The surgeon, taking call for the surgeon who actually performed the procedure, told the concerned nurse that he was told not to expect pulses and increases the pain medication. Much too late, the patient was found to have a clotted left limb and a flawed outflow anastomosis. This was corrected but too late. The delayed diagnosis and treatment ultimately led to amputation.

Defendant-surgeons also failed to solicit more information than volunteered by others with less insight, hoping that all was well rather than probing for confirmation or evidence to the contrary. For example, a resident called the attending during the night and reported admitting a patient with abdominal pain and who he thought was constipated. Ordinarily, one would expect that the admission of a patient with a diagnosis of constipation to a surgery service would require explanation, but the attending asked no questions. The patient expired that same night. Autopsy findings revealed a ruptured aneurysm, and a review of the records revealed that the patient was anemic and hypotensive in the emergency department before admission.

Whether poorly prioritized or oversolicited, the precious commodity of time was all too often lacking in the reviewed claims, resulting in the failure on the part of defendant-surgeons to convey important information. Consider the example of a general surgeon and a neurosurgeon sharing the care of a patient with multiple injuries in the emergency department. The computed tomography scan was negative for intracranial hemorrhage, and a decision was made to transfer to a different facility. Before transfer, the patient's neurological condition deteriorated, but the general surgeon in attendance, without communicating first with the neurosurgical consultant, misguidedly transferred the unstable patient, making a bad outcome presumably worse.

Communication failures occurred in cases involving surgical procedures (70 of 414 claims) and in cases in which no surgical procedure was performed by the defendant-surgeon (20 of 46 claims). When care involved surgery, the communication error occurred predominantly during the preoperative period in 26 cases, during surgery in nine claims, and during postoperative care in 35 claims.

Preoperative communication breakdown

Of the 26 failures during preoperative care, 14 were major contributors to subsequent substandard intraoperative performance. These cases included the following:

- Performing the wrong procedure in six claims, including the surgeon who operated for an anal fissure and performed fissurectomy and sphincterotomy but added hemorrhoidectomy based on newfound intraoperative observations. During the preoperative consent process, the surgeon failed to obtain the information that the patient was totally opposed to hemorrhoidectomy because of the previous bad experience of a friend. The consent did not include hemorrhoidectomy.

- Operating at the wrong site, which occurred in three claims, for example, the surgeon who failed to confirm the site of a cutaneous malignancy for wide excision from among several sites shaved by a dermatologist and proceeded to excise the wrong site.

- Injuring unintended organs, as happened in two claims. One example is the surgeon who, while removing a cystic hygroma, caused nerve injury, a possibility that was neither discussed with or consented to by the patient.

- Operating unnecessarily, as occurred with one claim. In this case, a lymph node regressed after the decision to biopsy and before surgery, but the surgeon failed to visit with and examine the patient in the day surgery department before surgery. The patient was prepared and draped and the surgeon gowned and gloved. The surgeon concluded that the node was not palpable because of the patient's positioning. The area was explored and no pathologic tissue was found.

- Inducing aspiration pneumonia, which occurred in one claim. In that example, the surgeon failed to be sure that the anesthesiologist knew that the patient had a full stomach with an air fluid level on an imaging study.

- Operating prematurely, as was the case in one claim. In that example, the surgeon failed to learn from the radiologist or gastroenterologist about leaking contrast at a sphincterotomy site before proceeding with laparoscopic cholecystectomy. Confusion was created by the tandem procedures; the treatment of a bileoma in the postoperative period was compromised.

Data show that preoperative failures in communication also were responsible for adverse events in the postoperative period in seven claims. A surgeon in one example was called to the operating room by a gynecologist who had injured the rectosigmoid region. The surgeon found a profound injury and performed an end-transverse colostomy and a mucus fistula. The patient did well and three weeks after surgery wanted the ostomy reversed. When the surgeon refused, the patient found a second surgeon who proceeded to close the ostomy without communicating with the first surgeon to learn about the severity of the injury. After reversal, pelvic peritonitis required additional operative procedures, including a second ostomy, in the face of additional complications.

In addition, among these preoperative failures, five claims were precipitated, even though the defendant-surgeons met the standard of care. Their paltry efforts failed to provide patients enough information with which to understand

that the adverse events experienced were a consequence of surgical disease, comorbidities, or other problems and that the events occurred in spite of, not because of, the surgeons. For example, a patient required an amputation after a bypass graft failed and sued because the surgeon did not adequately explain preoperatively that graft failures occasionally occur in spite of properly performed surgery.

Operating room communication breakdown

Communication problems in the operating room were relatively infrequent but nonetheless important. Problems such as the following were found during the claims review:

- Wrong site surgery in one claim, as in the case of one nurse who picked the patient up from the holding area, another nurse who prepared the patient for surgery, and another nurse who draped the patient for femoropopliteal bypass, followed by the surgeon entering the room and, with no questions asked, proceeding to operate on the wrong limb.
- Retained foreign body in two claims; in one example, after counting sponges, the circulating nurse reported that, excepting the sponges on the operative field, the count was correct. The surgeon heard only that the count was correct.
- Inappropriate use of medications in three claims, such as a colonoscopy where a patient was inadequately sedated and, without soliciting information regarding the medications already given, the surgeon asked the nurse to give additional sedation. Belatedly, after a severe complication from hypoxia, it was revealed that the patient had been profoundly overdosed; a faulty intravenous line led to the subcutaneous infusion of sedatives, the effects of which were delayed.
- Flawed assistant surgeon or consultant surgeon interactions occurred in three claims. In one example, a victim of penetrating trauma was found at laparotomy to have small bowel injuries. The attending surgeon resected two segments. At that point, the attending was called to the emergency department and left the less-experienced assistant surgeon to continue. Inadequately informed as to how to proceed, the assistant established intestinal continuity

between the most proximal and most distal limbs and anastomosed the excluded segment to itself, creating a perfect circle. The recovery was delayed and a second operation was required at a later date.

Postoperative communication breakdown

The failure to deal diligently with the consequences of intraoperative errors and other postoperative complications during the postoperative period also breaches the standard of care. Of the 35 cases involving failed communication during postoperative care, complications were caused or aggravated in 24 patients. Twelve claims involved problems with diagnosis, including the example of a patient who called daily after discharge following laparoscopic repair of a ventral hernia and was told each time that all was well but, on the third day, after reporting to the emergency department in desperation, was found to have an iatrogenic small bowel injury. The other 12 claims involved problems with treatment, such as the case where the nurse called the surgeon and reported that a patient who had a thyroidectomy earlier that day was complaining of trouble swallowing and anxiety. The oxygen saturation was 97 percent. The surgeon ordered additional sedation. When the nurse called the second time, the surgeon reported to the bedside but too late to prevent permanent disability caused by delayed treatment of a wound hematoma.

Even though the basic complication in the majority of these cases was inevitable, the delay or failure to diagnose or treat that resulted from flawed communication drastically increased the severity of the complication. For example, prompt diagnosis and/or treatment of complications such as postoperative infection, thrombosis, or bleeding would have prevented permanent disability; disastrous outcomes occurred instead when failure to communicate resulted in delays that led to organ system failure, amputation, or exsanguination.

Among the remaining 11 cases of postoperative failure, quality was not adversely affected by failed communication. Among these claims, the standard of care was met in 10. In these cases, as with similar claims involving preoperative care, defendants suffered litigation solely because

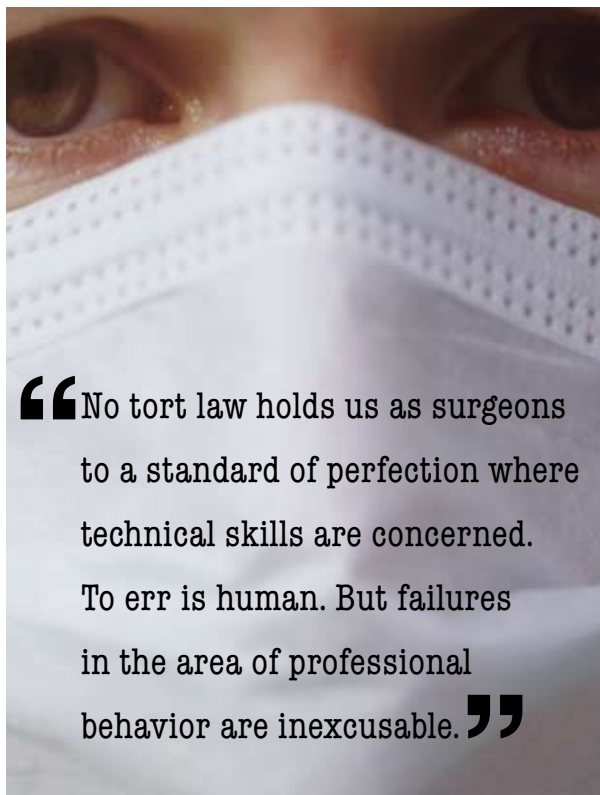
they failed to spend the time required to provide the insight and satisfaction necessary to defuse anger and mistrust. In the remaining case, dishonesty and deception did not affect outcome, but failed ethics—such as the case of a patient who suffered a significant though self-limiting musculoskeletal injury during transfer from operating table to stretcher but was informed of the event by a different health care provider and not the surgeon—will never meet standards.

Claims involving no surgical procedure

Problems in the subset of claims involving care by surgeons that did not include a surgical procedure were unique. Communication failures occurred in 70 of 414 (16.9%) of claims involving an operation and 20 of 46 (45.6%) of claims in which no surgical procedure was performed. This difference seems startling, but upon reflection, it might be expected since nonoperative care precludes the diluting effect of intraoperative and postoperative misadventures. It is enlightening to know that surgeon-defendants could have eliminated errors and/or litigation in almost half of nonoperative cases simply through improved communication. Nine diagnosis errors, seven treatment errors, and five suits with no errors resulted from these failures. In one example, a surgeon discharged a patient after observation for blunt abdominal trauma, noting that there was no pain or complaint but failing to confirm with the nurse that repeated doses of pain medications had been given just before the surgeon's visit. Given the opportunity, the nurse could also have reported a not-as-yet recorded temperature spike. The patient expired at home later the same day. The autopsy revealed a perforated hollow viscus.

Reviewers' observations

The claims reviewers made some general observations aside from the data that were collected. Many were humbled by the realization that they, too, had communicated poorly on occasion but without resulting litigation. In fact, closed claims drastically underreport errors of all kinds in that near misses are not included and a large majority of injured patients never



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file a claim. Reviewers also observed that communication problems resulted from the failure to diligently spend enough time to accomplish ordinary tasks rather than the failure to possess skill and brilliance to accomplish extraordinary feats. No tort law holds us as surgeons to a standard of perfection where technical skills are concerned. To err is human. But failures in the area of professional behavior are inexcusable, and diligently spending the required time certainly falls into that rubric.

Addressing the problem

In view of the documented extreme importance of communication in maximizing the effectiveness and safety of our surgical skills, the ACS Division of Education offers Fellows a course entitled “Surgeons As Effective Communicators: Sharpening Skills for Critical Moments.” This

three-day course helps participants use effective verbal and nonverbal communication skills across the spectrum of surgical encounters, especially in difficult situations and settings. Real-life clinical and administrative scenarios are used, such as handling adverse outcomes and errors, tense situations in the operating room, patients refusing life-saving treatment, angry or litigious patients, grieving families, unreasonable requests from superiors, difficult staff who require counseling, and impaired or incompetent colleagues. Participants gain practical experience through planned and impromptu scenarios involving trained actors and surgeon actors. Personal videotapes and feedback are provided to each participant by the course faculty, led by Chair L. D. Britt, MD, MPH, FACS. The next course will be offered in fall 2007.

Discussions are under way regarding development of a CD-ROM to enhance knowledge and skills in this competency. In addition, the *Disclosing Surgical Error: Vignettes for Discussion* DVD demonstrates two approaches used by a surgeon to disclose to the patient's family a major technical error that occurred in the operating room. Techniques that are effective and techniques that need to be improved are demonstrated in the scenarios. The vignettes can be used as free-standing trigger tapes for small group discussions with surgeons, surgical residents, and medical students, or the vignettes may be incorporated into a comprehensive course or curriculum. This DVD was supported by a grant from the Agency for Healthcare Research and Quality and is available at no cost at https://web2.facs.org/timssnet464/acspub/frontpage.cfm?product_class=keepcur. A second DVD presenting recent research findings on disclosure and additional vignettes and discussion items is slated to be released at the end of this year.

Conclusions

The effect of failure to communicate on surgical patient safety and liability is profound. Among the 460 claims reviewed in the ACS Closed Claims Study, 90 were filed largely as a consequence of failed communication. Even when the standard of care was met, as it was

in 25 percent of this subset of cases, failed communication led to anger, mistrust, and litigation. Of greater importance, though, reviewers found that poor communication led to preventable adverse events in some cases and increased both the morbidity and mortality of adverse events regardless of their cause in others. It follows that if we communicate well, we will reduce anger and mistrust, the number of preventable adverse events, the morbidity and mortality of many other adverse events regardless of their causes, and litigation as secondary gain. Realizing these benefits, the ACS Division of Education is aggressively providing Fellows with programs and materials on the competency of communication. ^Ω

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