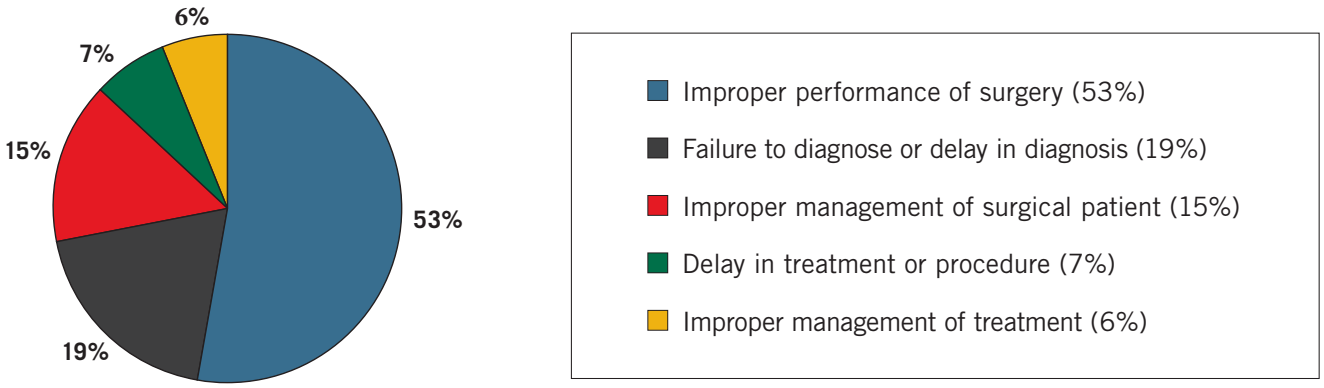
Otolaryngology Closed Claims Study

211 total claims (2007–2011)

Top Five Allegations (93% of Total Claims)

Patient's/plaintiff's view of the cause of the perceived injury



Twenty-three of the claims (11%) involved endoscopic sinus surgery, and of those 23 claims, 21 (91%) involved the ethmoid sinus.

Notes:

Improper performance of surgery was the most common patient allegation. This is consistent with the findings of expert reviewers, who identified technical performance as the factor that contributed to patient injury in 46% of cases (see page 2). However, closer review reveals that most (86%) of the factors identified as technical performance issues were known complications and not substandard care. This discrepancy between the patient's perception and that of expert reviewers may have resulted from either ineffective communication or incomplete disclosure during the informed consent discussion (see "Insufficient or lack of documentation" on page 2) or from the physician's failure to remind the patient that the postoperative complication was discussed during the informed consent.

The second most common allegation was failure or delay in diagnosing the patient's condition. This is supported by the finding of inadequate patient assessment in 23% of the cases. Deficiencies included failure to establish a differential diagnosis, failure to order diagnostic tests, and failure to utilize available clinical information. Examples included:

- A patient presented with dizziness and hearing loss. Allergy was suspected and treated symptomatically, and a CT scan was never ordered. The final diagnosis was cerebellar meningioma.
- Post cricopharyngeal myotomy, a patient experienced chest discomfort and subcutaneous emphysema. He was treated conservatively, and a CT scan was not performed. Esophageal perforation with mediastinitis was diagnosed seven days later.
- A patient presented with right facial paralysis, which was diagnosed as Bell's palsy. Symptoms worsened, but an MRI was not performed. Carcinoma of the parotid gland was eventually diagnosed.

The diagnostic categories most frequently associated with these diagnosis-related claims included malignant neoplasms (larynx, nasopharynx, tongue, ethmoid sinus, and salivary gland), which accounted for 60% of claims, and delay in diagnosing surgical complications (nerve compression by hematoma, hemorrhage, perforation of sinuses, and CSF leak), which accounted for 20% of claims. Failure to diagnose benign neoplasms (cranial nerves and cerebral meninges) and infections (*Streptococcus,* MRSA) each accounted for 10% of claims.

The allegation of improper management of surgical patient refers to problems that arose during postoperative care and included patient death, brain damage resulting from opiate overdose or undiagnosed sleep apnea, and delay in responding to a surgical complication such as hemorrhage, subdural hematoma, and a screw impinging on a nerve.

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Factors Contributing to Patient Injury

The view of expert physicians and clinical analysts on the underlying causes of patient injury

1. **Technical performance (46%)**
   a. Known complications were identified in 86% of cases arising from allegations of poor technical performance
   b. Poor technique (diplopia due to sinus perforation with muscle injury, blindness due to damage to optic nerve, nasal cautery burn, infection from CSF leak)
   c. Retained foreign body (packing material, bone fragments)
2. **Patient factors (42%)**
   a. Patient not compliant with follow-up call or appointment
   b. Patient not compliant with treatment plan
   c. Patient not compliant with prescribed medication
3. **Patient assessment issues (23%)**
   a. Failure to establish a differential diagnosis (pain suspected to be from fracture actually resulted from screw impingement on a nerve)
   b. Failure to order diagnostic tests
   c. Failure to utilize available clinical information (patient died from respiratory arrest following extubation and discharge—the medical record documentation of respiratory distress and the bronchoscopy report were not reviewed)
4. **Communication between patient/family and provider (17%)**
   a. Poor patient rapport
   b. Inadequate informed consent for surgical procedure
   c. Patient education regarding follow-up instructions
5. **Insufficient or lack of documentation (14%)**
   a. Informed consent (regarding known risks of surgical procedures)
   b. Clinical findings (lack of detail in op reports, follow-up visits, and treatments)

Notes:
Technical performance was the most common factor contributing to patient injury. However, when cases involving known complications (86%) were excluded, actual performance issues were identified in only 14% of claims. The procedures associated with technical performance issues included ethmoidectomy (17%), facial rhytidectomy (8%), septoplasty (6%), and 38 miscellaneous procedures. The resultant complications included penetration of sinus walls causing double vision or blindness, improper placement of inner ear prostheses causing balance disturbance, damage to the optic nerve during pituitary resection, incomplete tonsillectomy causing pain and infection, and incomplete removal of sinus packing causing infection.

Patients play an important role in managing their clinical outcome. Reviewers noted in 19% of claims that patients failed to comply with treatment instructions, medication plans, and follow-up appointments. A factor that may affect the level of patient compliance is communication between patient/family and the provider, which was identified in 17% of the cases. In addition to poor patient rapport, communication problems included inadequate informed consent for surgical procedures and ineffective patient education regarding follow-up instructions.

Inadequate documentation was noted in 14% of claims, and the most common problem was failure to document informed consent regarding complications of sinus surgery (double vision, blindness, CSF leak, meningitis, nerve injury, and infection). In addition, reviewers noted inadequate documentation of clinical findings, clinical history, follow-up care, and patient refusals of treatment.

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