Learning from malpractice in bariatric surgery

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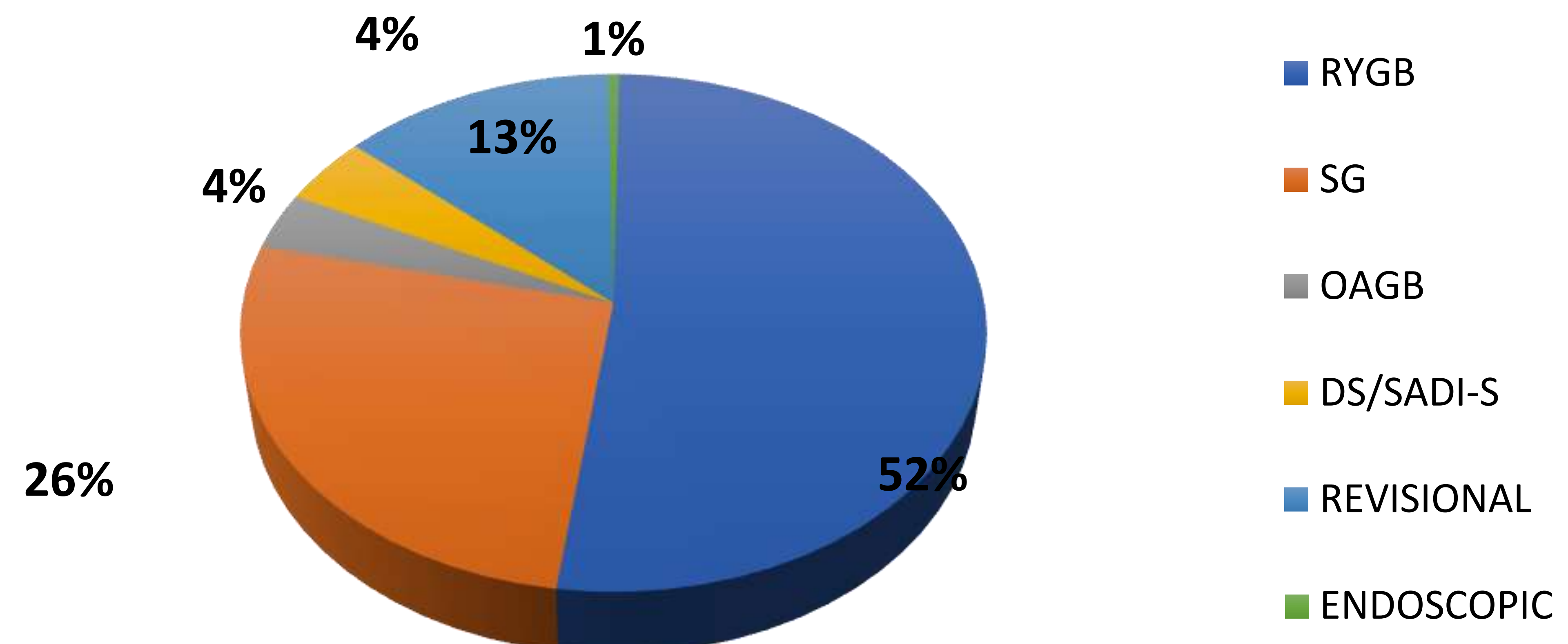
  - ETHICON CONSULTANT
  - Abex Spain with robotic course organization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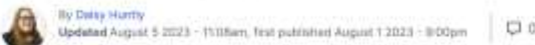


The Daily Advertiser

Court

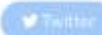
Supreme Court finds in favour of Wagga surgeon Richard Harrison in failed negligence lawsuit

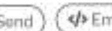
By Daisy Huntly
Updated August 5 2023 - 11:08am, first published August 1 2023 - 9:00pm

0 Comments

July 25, 2023

W Supreme Court Considers Inherent Risk and r Professional Opinion in Bariatric Surgery Case Polsen v Harrison (No. 8)

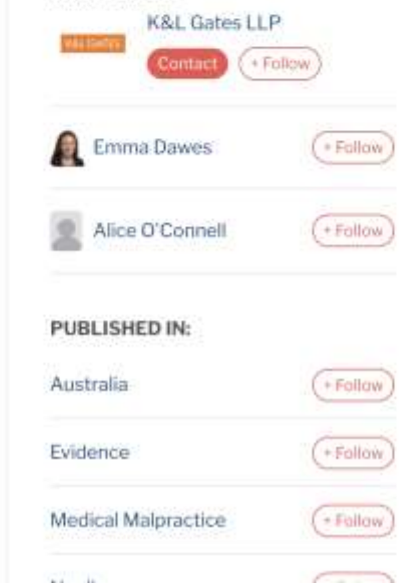




023, Lonergan J found in favour of Dr Harrison (Defendant), in a iatric surgery case brought by Katrina Polsen (Plaintiff). A full be read here.

ıd

2013, the Plaintiff underwent a sleeve gastrectomy procedure y the Defendant to manage her morbid obesity. She developed an early post-operative leak, which required her to return to theatre for a laparoscopic washout and insertion of peritoneal drain. She subsequently had a difficult and complex post-operative course due to intermittent sepsis and malnutrition, involving many admissions to hospital and multiple surgical



Tiempo de lectura: 3 min. 24 mayo 2023

Tribunal ofició a Fiscalía para que investigue el caso

Joven fallece en Antofagasta tras cirugía bariátrica: familia presentó querella contra la clínica y personal médico

La estudiante de 20 años cursaba tercer año de Química y Farmacia en la Universidad Católica del Norte. "Me duele mucho la espalda", alertó la joven un día después de recibir el alta médica.

Diario de Sevilla ANDALUCÍA

OCIEDAD DEPORTES CULTURA COFRADÍAS OPINIÓN TODAS LAS SECCIONES

ÉN MÁLAGA SEVILLA

ıa una indemnización de un a un paciente del SAS

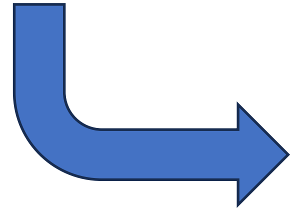
rención de cirugía bariátrica provocó secuelas irreparables

:ia que El Defensor del Paciente ganó en primera y segunda

das interpuesta por una mala praxis en un hospital del SAS

Todos los resultados de las elecciones generales 2023

Medical errors are a serious public health problem and a leading cause of death in the United States.



By recognizing untoward events occur, learning from them, and working towardpreventing them, patient safety can be improved.

Oyebode F. Clinical errors and medical negligence. Med Princ Pract. 2013;22(4):323-33.

- Impact for the physicians

Psychological effects such as anger, guilt, inadequacy, depression, and suicide due to real or perceived errors.

- Impact to the system.

- Impact for the patients.

Fear of punishment makes healthcare professionals reluctant to report errors.

Robertson JJ, Long B. Suffering in Silence: Medical Error and its Impact on Health Care Providers. J Emerg Med.2018 Apr;54(4):402-409.

Medical malpractice occurs when a healthcare professional provides you with care that does notmeet the proper standard.

- Errors of omission occur as a result of actions not taken.
- Errors of the commission occur as a result of the wrong action taken

We have a duty to offer the patient competent care.

Performed without the required level of skill.

- Malpractice
- Be held accountable for the consequences

Battard J. Nonpunitive response to errors fosters a just culture. Nurs Manage. 2017 Jan;48(1):53-55.

Examples of Medical Malpractice

- Misdiagnosis
- Delayed Diagnosis
- Failure to Obtain Informed Consent
- Incorrect Treatment
- Treatment Mistakes
- Surgical Malpractice
- Birth Injuries
- Wrongful Death

Current Obesity Reports
https://doi.org/10.1007/s13679-023-00508-1

REVIEW

Medicolegal Cases in Bariatric Surgery in the United Kingdom

Matyas Fehervari[1,2] · Michael G. Fadel[2] · Marcus Reddy[1] · Omar A. Khan[1,3]

Postoperative mortality rate of 0.04% and complication rate of 2.4% for bariatric surgical procedures

Total number of cases and number of claims → *USA: 19.4/ year*

UK: 0.7/year

Timsit G, Johanet H. Medico-legal claims in bariatric surgery in France between 2010 and 2015. J Visc Surg. 2019;156(Suppl 1):S51–5.

Vilallonga R, Pereira-Cunill JL, Morales-Conde S, Alarcon I, Breton I, Dominguez-Adame E, et al. A Spanish society joint SECO and SEEDO approach to the post-operative management of the patients undergoing surgery for obesity. Obes Surg. 2019;29(12):3842–53.

Lazzati A, Guy-Lachuer R, Delaunay V, Szwarcensztein K, Azoulay D. Bariatric surgery trends in France: 2005–2011. Surg Obes Relat Dis. 2014;10(2):328–34.

Physician Insurers Association of America database

1990–1999 and 2000–2009

575 claims identified

gastric bypass was the most frequent procedure

The number of morbid obesity claims increased from nine during the initial period to 249 in the subsequent period: → significant increase in the number of bariatric operations performed.

Weber CE et al. Comparing 20 years of national general surgery malpractice claims data: obesity versus morbid obesity. Am J Surg. 2013;205(3):293–7;

Negligence → failure to detect complications in a prompt manner as opposed to the complications themselves.

100 consecutive bariatric surgery lawsuits.

Causes:

- *Anastomotic leaks*
- *intra-abdominal abscess*
- *bowel obstruction*
- *major airway events*
- *Organ injury*
- *pulmonary embolism*

32 patients: documented intraoperative complication
72 required subsequent surgery.

53 patients died
28 made minor or major disability

Lawyer revealed potential negligence in 28% of cases with delay in diagnosis of a complication or misinterpretation of vital signs being the most common cause.

The majority of lawsuits involved surgeons with less than 1 year of experience in bariatric surgery.

Cottam D et al. Medicolegal analysis of 100 malpractice claims against bariatric surgeons. Surg Obes Relat Dis. 2007.

Cirugía Española

Volume 90, Issue 4, April 2012, Pages 254-259

Original

Análisis médico-legal de las reclamaciones judiciales en cirugía bariátrica

Medicolegal analysis of legal claims in bariatric surgery

Miquel Bruguera [a] [b], Salvadora Delgado [c], Mercè Viger [b], Josep Benet [a], Roger Bruguera [a], Josep Arimany [a]

49 Spanish medicolegal bariatric surgery cases

from 1992 to 2009

47% of the cases, the patients died,
21% made a complete recovery
32% residual impairment.

Anastomotic leaks
Respiratory complications

Malpractice was considered to have occurred in 20%
6% of cases the surgeons were convicted in criminal courts of criminal negligence.

Bruguera M et al. J. Medicolegal analysis of legal claims in bariatric surgery. Cir Esp. 2012;90(4):254–9.

Surgery for Obesity and Related Diseases 19 (2023) 76–77

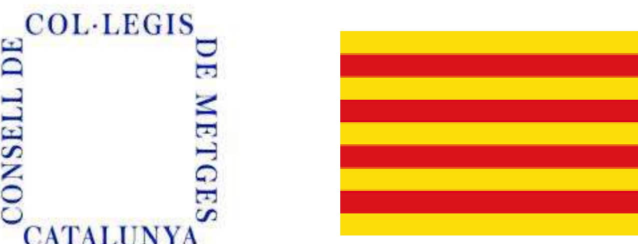
SURGERY FOR OBESITY AND RELATED DISEASES

Letters to the Editor

Learning from error in bariatric surgery: analysis of malpractice closed claims in Spain

January 1, 1986, to December 31, 2021

Claims database of the Professional Liability Service of the Catalonian Council of Physician's Official Colleges.



35 years
10,567 claims.

840 were related to digestive surgery procedures (7.95%)

91 (0.86%) were related directly to bariatric surgery
→ *including 28 related to postoperative death (30.77%).*

The reasons given for the claims were various

- Main causes were defect of surgical practice (60.0%, 51 cases, 24.0% with liability)

- Perioperative complications after the procedure (40.0%, 34 cases, 23.5% with liability).

- *Sleeve gastrectomy: 48.2%, 41 cases, 18 deaths, 19.5% with liability*
- *Gastric bypass (24.7%, 21 cases, 5 deaths, 33.3% with liability*
- *Intragastric balloon (15.3%, 13 cases, 1 death, 7.7% with liability*
- *Gastric band (3.5%, 3 cases, no deaths, 66.7% with liability*

<u>85 closed procedures:</u>

67.3% after complete judicial procedure “without liability,”
26.7% claims ended in a pay-out (either by conviction or out-of-court settlement)

A total of 69.3% claims of closed procedures had court involvement (at least started through the courts; 57.7% at civil courts and 42.3% at criminal courts, resulting in liability in 46.7% of civil cases and 13.6% in criminal cases.

The average compensation in paid claims was 250,023.17 Euro (maximum of 770,695.89 Euro and minimum of 7783.42 Euro),

Surgery for Obesity and Related Diseases 18 (2022) 943–947

Original article

First report from the American Society of Metabolic and Bariatric Surgery closed-claims registry: prevalence, causes, and lessons learned from bariatric surgery medical malpractice claims

John M. Morton, M.D., M.P.H.[a,*], Habib Khoury, B.S.[b], Stacy A. Brethauer, M.D.[c], John W. Baker, M.D.[d], William A. Sweet, M.D.[e], Samer Mattar, M.D.[f], Jaime Ponce, M.D.[g], Ninh T. Nguyen, M.D.[h], Raul J. Rosenthal, M.D.[i], Eric J. DeMaria, M.D.[j]

[a]*Department of Surgery, Yale School of Medicine, New Haven, Connecticut*
[b]*School of Medicine, University of California, Los Angeles, California*
[c]*Department of Surgery, Ohio State University, Columbus, Ohio*
[d]*Department of Surgery, Tulane University, New Orleans, Louisiana*
[e]*Department of Surgery, The Reading Hospital and Medical Center, West Reading, Pennsylvania*

Period from 2006–2014

175 closed claims

75.9% of surgeons were board certified
43.3% of the hospitals were accredited for bariatric surgery.

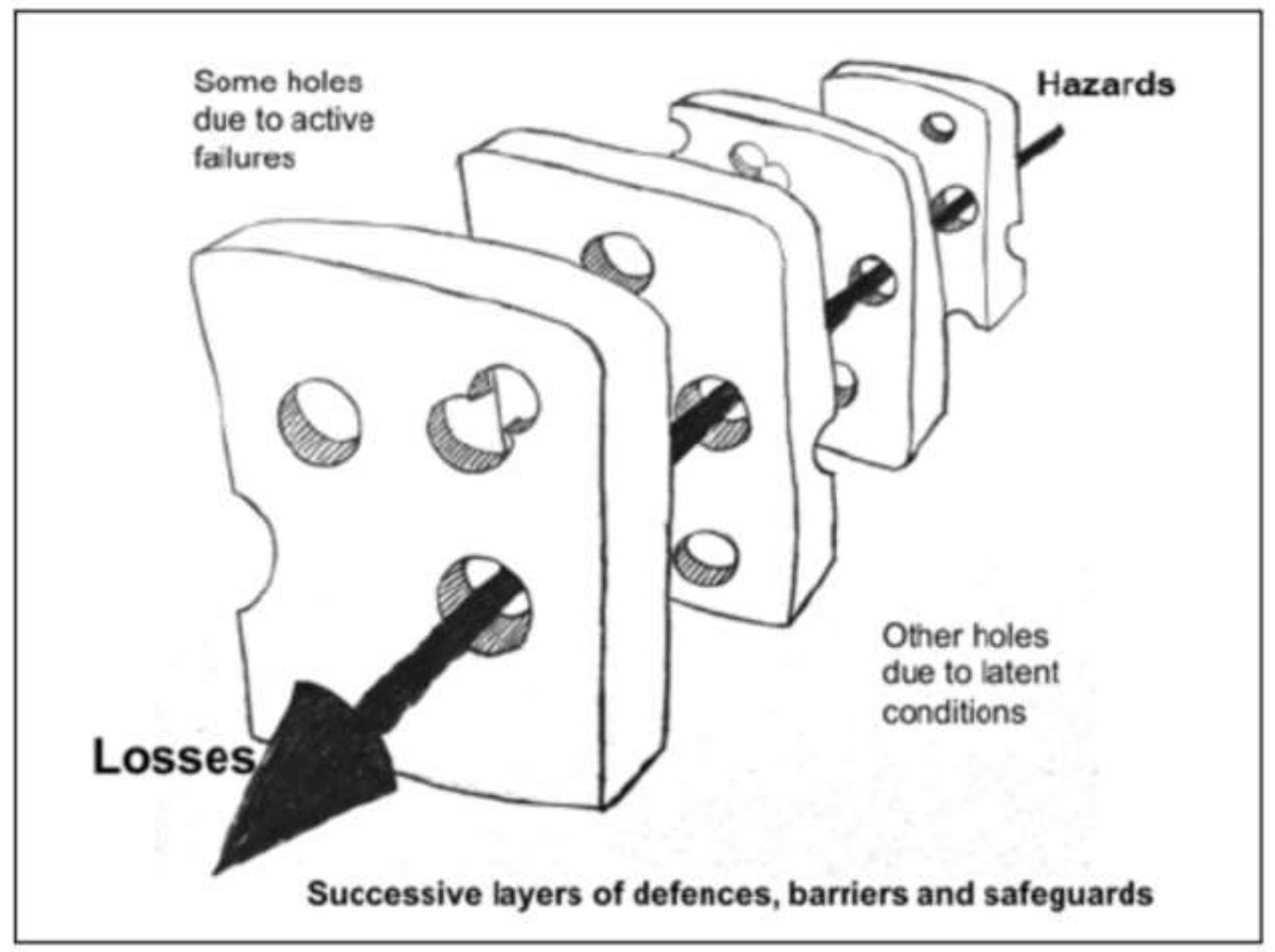
Most clinical complications after bariatric surgery that led to malpractice lawsuits were:

- Mortality (35.1%)
- Leaks (17.5%)
- Bleeding (5.3%)
- Retained foreign body (5.3%)
- Vascular injury (4.4%)

Prevalence of malpractice claims regarding bariatric surgery is low.

- Failure to diagnose
- Delay in treatment
- Postoperative care
- Communication domain responses

→ indicate future opportunities for improvement.


Some holes
due to active
failures
Hazards
Other holes
due to latent
conditions
Losses
Successive layers of defences, barriers and safeguards

Prevention of Surgical Errors

- Errors in surgery do not arise spontaneously.
- They develop from the interaction of multiple people and equipment.
- In order to decrease surgical errors, providers need to know when and where errors may occur

The key risk factors to be aware of include:

- An attitude that a surgeon’s decisions should not be questioned.
- Distraction
- Incomplete or missing pertinent imaging information and relying on memory.
- Incomplete preoperative assessments
- Multiple surgeons performing more than one procedure.
- Poor staffing.
- Wrong-site surgery
- Wrong labeling of the specimen or even discarding the specimen as waste.

Surgical Time

- Adopting a checklist of things that must be done. Prior to induction of anesthesia two independent healthcareprofessionals must confirm the patient's identity, site of surgery, type of procedure, and review the consentform.

- Prior to making the skin incision, the anesthesiologist, surgeon, and nurse must again confirm the identity of thepatient and confirm the type of surgery. This team also identifies the need for antibiotic prophylaxis and deepvein thrombosis prevention maneuvers.

- After completion of the surgery but before leaving the operating room, the surgeon, anesthesiologist, and anurse verbally conclude the completeness of the count of instruments and sponges, verify that the specimen islabeled, and note the clinical status of the patient.

Health professionals:

Standardize equipment.

Be involved in setting and evaluating institutional, organizational, and public policy related to technology.

Make sure that the technology used meets quality and safety standards.

Institutions should:

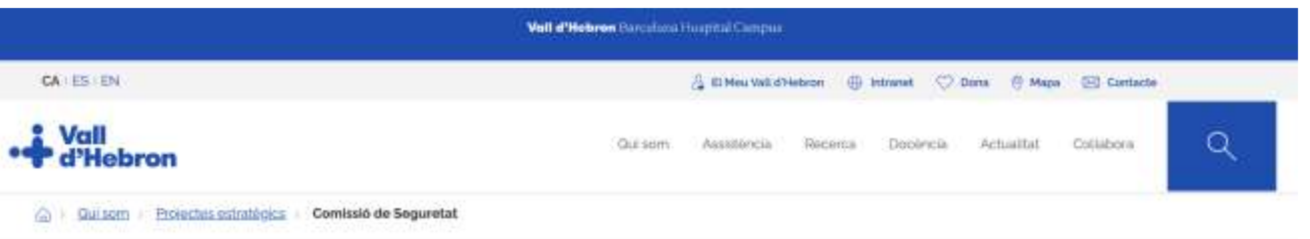
Make decisions concerning technology with the input of critical stakeholders

Have policies and processes related to maintenance, training, monitoring, and reporting adverse events relatedto technology.

Bouldin E. J Patient Saf. 2013

General	Adhere to guidelines provided in all aspects of the bariatric surgical care, for example indication, investigation, surgical technique, by relevant organisations such as ASMBS, IFSO or NICE. In addition, ensure all patients have been discussed at a specialist bariatric multidisciplinary team meeting
	Ensure that all documentation, including medical records, surgical notes and consent forms are clear, legitimate and accurately reflects the consultation that was held with the patient
	Communicate clearly and use adjuncts such as leaflets, images and videos. Provide ample opportunity for the patient to ask questions and clarify any doubts. Offer patients with contact information of the Bariatric Team in order to can query waiting times and book appointments
Consent	Obtain informed consent from patients in advance of the day of the operation. Explain the surgical and conservative options available, explain the different type of operations and outcomes as well as the risks and benefits associated with each of them
	Consent form: ensure that all possible surgical and conservative short- and long-term complications risks are presented to the patient including changes to body shape, psychological issues and weight regain
	Avoid consenting on the day of the operation but do confirm the consent
Technical factors	Conduct appropriate preoperative investigations, such as blood tests, imaging studies and endoscopy, to ensure that the patient is a suitable candidate for surgery. Ensure patient has been cleared by dietitians and clinical psychology
	Perform operation competently by using careful surgical technique with attention to details. Avoid all but particularly gross technical errors at all cost (such as Roux-en-O)
	Construct a clear operation note, include a clear description of the surgical technique and equipment used, such as staplers, size of the bougie and any other relevant details
	Conduct quality control of the operation (for example a leak test, record the surgery and take intraoperative photographs)
Postoperative care	Conduct daily reviews of the patient's progress post-surgery and document the surgical plan each day, with particular consideration of pain and nausea management
	Avoid failure to rescue by effective communication with team members, regular monitoring of the patients and have an emergency response plan/investigation sequence in place
	Provide appropriate long term postoperative care, including monitoring for complications, providing nutritional guidance and adequate outpatient follow-up

ASMBS American Society for Metabolic and Bariatric Surgery, *IFSO* International Federation for the Surgery of Obesity and Metabolic Disorders, *NICE* National Institute for Health and Care Excellence



Comissió de Seguretat

- Proposes and prioritizes strategies in the field of patient and professional safety
- Promote improvement actions related to patient and professional safety
- Oversees the monitoring of patient and professional safety indicators and evaluates the results

Semiología de la emergencia abdominal | Unidad 2

#Índice

UNIDAD 2

Características específicas de la semiología de la emergencia abdominal con un antecedente bariátrico reciente o lejano: disfagia, vómitos, taquicardia, disnea, taquipnea, fiebre, hipotensión, oliguria y hemorragia. Exploración física.

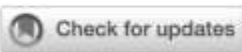
- Patient's satisfaction.
- Make notes about their families,hobbies, and anything else that can help you establish a good relationship
- Review patients' charts before the exam
- Communicate clearly and educate thoroughly
- Keep updated with advances in healthcare and technology (you and your team)

- *Appropriate consent process*
- *Careful surgical technique*
- *Multidisciplinary involvement Pre- and postoperatively*
- *Robust follow-up protocols*

The risks can be reduced and mitigated

Frontiers in Medicine

TYPE Original Research
PUBLISHED 21 October 2022
DOI 10.3389/fmed.2022.960418



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SPECIALTY SECTION
This article was submitted to Healthcare Professions Education, a section of the journal Frontiers in Medicine

RECEIVED 02 June 2022

Promoting a culture of sharing the error: A qualitative study in resident physicians' process of coping and learning through self-disclosure after medical error

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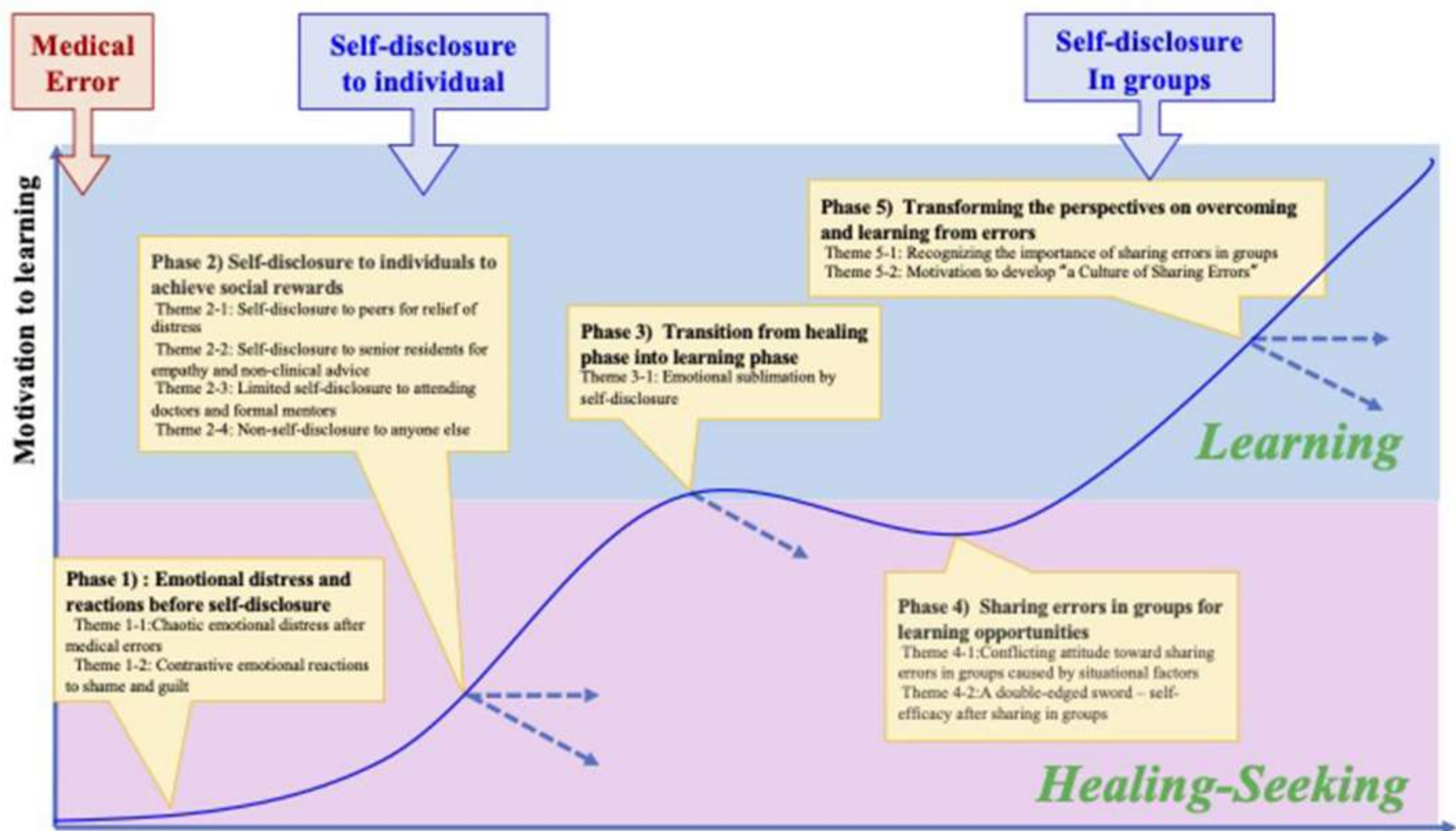
Dr. Ramon Vilallonga



Thank you and keep safe !!

@drvilallonga