This publication contains an analysis of the aggregated data from MedPro Group’s ENT claims closed between 2005 and 2014. All claims included in this analysis identify an ENT physician as the primary responsible service. Claims in which another specialty is identified as the primary responsible service are not included, unless otherwise noted.

This analysis is designed to provide MedPro Group insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed claims data to assist them in purposefully focusing their risk management and patient safety efforts.

Data are based on claim counts, not on dollars paid (unless otherwise noted). The type of claims and the details associated with them should not be interpreted as an actuarial study or financial statement of dollars paid; however, the information may be referenced for issues of relativity.

Please Note: *This report is divided into two sections — an executive summary and a more detailed analysis of allegations and risk factors. The executive summary begins on page 3, and the detailed analysis begins on page 7.*
Over the 10-year period analyzed, surgical treatment allegations accounted for 65% of all ENT claims and 60% of total dollars paid for defense and indemnity costs.

Within the surgical treatment claims, improper surgical technique was cited in two-thirds of the allegations. Inadequate preoperative and postoperative patient management, as well as lack of intraoperative patient monitoring, were noted in one-fourth of the allegations.

Surgical treatment allegations have consistently accounted for the majority of ENT claims over time; however, in recent years, diagnosis-related claims — primarily those involving oropharyngeal cancer — are increasing. Further, in the 10-year period analyzed, diagnosis-related allegations accounted for 27% of total dollars paid for all ENT claims.

Note: Any totals not equal to 100 percent are the result of rounding. The “other” category includes allegations for which no significant claim volume exists.
SURGICAL TREATMENT ALLEGATIONS BY PROCEDURE TYPE

Although no single procedure drives a majority of the surgical treatment claims, a few together represent 52% of the overall claim volume.

- Tonsillectomy & Adenoidectomy: 48%
- Ethmoidectomy: 12%
- Thyroidectomy: 11%
- Rhino/Septoplasty: 9%
- Destruction of Lesion: 8%
- Sialoadenectomy: 8%
- Other: 4%

Note: The “other” category includes procedures for which no significant claim volume exists.
KEY RISK FACTORS

- An inadequate informed consent process, which was noted in 20% of the surgical treatment claims and includes failure to document the consent discussion with the patient.

- Procedural inexperience, poor technique, misidentification of anatomy, and improper use of surgical equipment.

- Patient assessment problems, which often result in premature postoperative discharge.

- Failure to correlate patient complaints with additional diagnostic testing.

- Insufficient documentation of clinical findings and the rationale for treatment.
Improper procedural technique was cited in about two-thirds of the surgical treatment allegations, while inadequate preoperative and postoperative patient management, as well as lack of intraoperative patient monitoring, was noted in one-fourth of the surgical treatment allegations.

Diagnosis-related allegations involve a failure to diagnose or a delay in diagnosis. More than two-thirds of these allegations involve cancer — of these, half are associated with cancer in the nasopharynx and larynx.

Treatment-related allegations are a broad category related to management of a patient’s course of treatment. This category also includes nonsurgical office procedures. Conditions cited in medical treatment claims include Meniere’s disease, tinnitus, surgical procedure burns, and postoperative infections.

The “Other” category represents allegations for which no significant volume exists. Examples include medication-related claims, patient falls, and surgical equipment malfunctions.
Over time, surgical treatment has remained the top allegation category. However, beginning in 2009, these allegations have declined (although surgical treatment still represents the top allegation category). Conversely, diagnosis-related allegations began to increase in 2009 after a steady decrease in the preceding 5 years.

Note: The “other” category includes allegations for which no significant claim volume exists.
Although surgical treatment claims represent almost two-thirds of the ENT claim volume, diagnosis-related claims have a proportionately higher percentage of claims with serious outcomes.

Tonsillectomies and ethmoidectomies account for 25% of the high-severity surgical treatment claims. Obstructive sleep apnea (OSA) was noted in several instances to be a contributing factor to the outcome.

High-severity diagnosis-related claims most often involve missed or delayed diagnoses of cancer. These claims frequently are associated with (a) failure to order or delay in ordering diagnostic tests, and (b) failure to further pursue abnormal findings that were identified during clinical exam.

More than twice as many inpatient surgical patients have high-severity outcomes compared with patients treated in ambulatory surgery centers.

Note: Any totals not equal to 100 percent are the result of rounding
SURGICAL TREATMENT ALLEGATIONS BY SURGICAL SITE & PROCEDURE TYPE

Case Scenarios

- Dissection too far below the tonsil bed, resulting in nerve damage
- Excessive removal of tissue, resulting in palatal defects
- Burn to lip from electrocautery device
- Postoperative stroke in pediatric patient, which was related to inadequate management of OSA symptoms
- Consent given for adenoidectomy only, but actual surgery included tonsillectomy

*Includes all procedures on that site area

Note: Any totals not equal to 100 percent are the result of rounding. The “other” category includes allegations for which no significant claim volume exists.
DIAGNOSIS-RELATED ALLEGATIONS

Although diagnosis-related allegations represent only 17% of the ENT claim volume, they can be significant in terms of poor patient outcomes. The diagnosis-related cases often involve cancer, and most of the allegations are related to a failure to order or delay in ordering diagnostic testing, which is compounded by:

- A narrow diagnostic focus, especially when faced with an atypical presentation or symptoms matching a chronic, previously known condition
- Misinterpretation of diagnostic studies
- Failure to pursue an abnormal finding

Top Conditions Associated With Diagnosis-Related Allegations

Cancer Diagnoses by Type

Note: Any totals not equal to 100 percent are the result of rounding. The “other” category includes allegations for which no significant claim volume exists.
**TOP RISK FACTORS IN SURGICAL TREATMENT CLAIMS**

Risk factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims.

Recognized complications were noted in half of all cases. Within those cases, half indicated a high likelihood of poor technique, which means the remaining cases in which a recognized complication occurred were affected by such issues as a poor informed consent process, poor provider communication skills resulting in a lack of patient understanding of the potential outcomes, a poor treatment plan, or insufficient documentation.

Inadequate informed consent process, leading to patients who experience unexpected outcomes

Inadequate patient assessment, including H&P’s, and failure to rule out abnormal findings and to respond to repeated patient concerns; sometimes leads to premature discharges

Failures in the communication process among providers (primarily in the inpatient setting); most notably related to complex surgical procedures and interactions with specialty consults and nursing

Insufficient documentation of clinical findings, rationale for treatment, and informed consent; most often associated with allegations of improper performance of surgery

- **Technical Skill**: 80%
- **Clinical Judgment**: 57%
- **Communication**: 39%
- **Documentation**: 24%

*Note:* Top factors within each risk category are identified. Totals do not equal 100% because more than one factor is associated with each claim.
FOCUS ON INFORMED CONSENT—SURGICAL TREATMENT CLAIMS

Communication risk factors encompass issues with discharge instructions, lack of patient education about medication risks, and language barriers. The primary issue in these cases, however, is inadequate informed consent, which relates to:

- The procedure performed (i.e., risks not explained, or additional procedures added while patient is in the operation room)
- Other treatment options (i.e., other options are not presented to or discussed with the patient)

Cases involving informed consent are significantly more costly in terms of total dollars paid than other claims involving communication as a risk factor. In fact, 72% of all dollars paid on surgical treatment claims with communication as a risk factor were associated with inadequate informed consent for the procedure performed.

Case Scenarios

- Failure to discuss and document the potential for wider surgical margins; patient experienced dysphagia following palate resection
- Failure to document discussion related to risk of facial nerve paralysis and hearing loss following debulking of cholesteatoma of the middle ear; patient developed both outcomes
- Failure to discuss and document risk of vision loss during sinus surgery; medial rectus muscle was inadvertently lacerated during surgery
- Failure to discuss low risk of palatal defect and velopharyngeal insufficiency prior to T&A; patient requires dental obturator to speak

Learn More:
An analysis by CRICO Strategies of malpractice cases linked to communication breakdowns revealed that 13% involved inadequate informed consent.¹

In this set of ENT cases, 61% of the surgical treatment cases involving communication breakdowns were specifically related to failures in the informed consent process.

CASE SUMMARY: IMPROPER PERFORMANCE OF SINUS SURGERY

A patient in her mid-sixties presented to her ENT physician with complaints of chronic sinusitis and a 3-month history of headache with facial pain and swelling, as well as purulent nasal discharge. A CT scan revealed a deviated septum, and a subsequent fiber optic exam identified a right-sided sinus blockage.

The patient agreed to a functional endoscopic sinus surgery at an ambulatory surgery center to drain the maxillary and ethmoid sinuses.

Although the ENT physician conducted an informed consent discussion with the patient, not all risks were covered, including the risk of vision loss.

Postoperatively, the patient complained of left eye pain, blurred vision, and limited downward eye movement. A CT scan revealed an interruption of the left medial wall of the medial rectus muscle. The ENT physician stated later that the laceration was likely due in part to use of a microdebrider machine that she had not previously used. The patient was discharged with an appointment to be seen by an ophthalmologist and prescriptions for an antibiotic and prednisone.

Upon consultation with the ophthalmologist, an urgent surgical exploration was arranged. The lacerated muscle was initially repaired, but did not hold. As a result, the patient now has diplopia and recurring headaches, and she is unable to drive or work.

Risk management issues for this case:

- Improper technical skill in relation to competency with surgical equipment
- Inadequate informed consent for the surgical procedure (failure to discuss all related risks)
- Failure to obtain a timely consult/referral
CASE SUMMARY: FAILURE TO DIAGNOSE NASOPHARYNX MALIGNANCY

A patient in his mid-sixties with a known history of exposure to asbestos and other chemicals several years prior presented to his ENT physician with complaints of nasal congestion, sinusitis, bronchitis, left ear pressure, recent hearing loss, and a history of nosebleeds with associated blood clots upon coughing.

A physical exam was performed, but it did not include endoscopic evaluation of the nose, nasopharynx, or larynx. The ENT physician diagnosed allergic rhinitis and Eustachian tube dysfunction. No documentation was made regarding the nosebleeds.

The patient returned several times for appointments over the next 2 months. He was treated with antibiotics and steroids, and he underwent a procedure to drain fluid from behind his eardrum. The ENT physician later stated that a CT scan had been ordered for the patient during the last office visit, but the order was not documented in the chart.

Two months later, the patient consulted with a second ENT physician, who performed a scope procedure and diagnosed a malignant nasal mass completely blocking the nasopharynx and left Eustachian tube. The patient underwent chemotherapy treatments, but he developed bony metastasis and subsequently died.

Risk management issues for this case:

Insufficient documentation of clinical rationale for treatment, as well as missing documentation related to the order for additional diagnostic testing

Inadequate patient assessment related to the patient’s prior history of exposure to known carcinogens

Failure to order additional diagnostic testing

Inappropriate selection of a course of treatment for the patient’s continuing symptoms
IMPORTANT RISK MITIGATION STRATEGIES

**TECHNICAL COMPETENCY**

- To minimize the risk of recognized complications, ensure adherence to credentialing policies, including evaluation of surgical skills and competency with surgical equipment.

**CLINICAL JUDGMENT**

- Conduct a thorough preoperative screening of patients for risk factors, including obstructive sleep apnea.
- Be aware that inadequate patient assessment might be a result of cognitive biases, inadequate medical and family history taking, or inadequate sharing of information among providers.
- Maintain a consistent postoperative discharge assessment process, and carefully consider repeated patient complaints or concerns when making clinical decisions about patient care and diagnostic testing.

**TEST ORDERING, TRACKING, AND FOLLOW-UP**

- Implement a formalized tracking system to monitor patient compliance with testing and scheduled appointments and timely physician review of results received. Ensure prompt communication to the patient of relevant findings from diagnostic testing, and seek timely consultations/referrals when necessary.

**INFORMED CONSENT**

- Adhere to a standardized informed consent process that includes common and significant risks that are relevant to the patient and the procedure. Information should be presented in a manner easily understood by the patient. A properly conducted and documented informed consent discussion can enhance the defensibility of a malpractice claim.

**PATIENT EDUCATION**

- Provide patients/caregivers with written and verbal instructions related to their treatment plans and follow-up care.
- Determine whether the patient has a realistic understanding of the expected results.

**DOCUMENTATION**

- Verify that documentation supports the clinical rationale for the diagnosis and treatment decisions. Describe the rationale for inclusion/exclusion of differential diagnoses.
KEY POINTS

Surgical treatment claims account for the majority of ENT claim volume and total dollars paid for defense and indemnity costs. The top risk factor for these claims is technical skill, which includes allegations of poor technique and improper use of surgical equipment.

The top surgical sites implicated in the surgical treatment claims are the sinuses, nose, tonsils/adenoids, and thyroid.

Additional top risk factors identified in the surgical treatment claims are inadequate communication, lapses in clinical judgment, and inadequate documentation.

Diagnosis-related claims tend to be significant in terms of poor patient outcomes. These claims primarily involve cancer diagnoses, specifically of the oropharynx. Clinical judgment issues, such as inadequate patient assessment and maintaining a narrow diagnostic focus, are contributing factors in the diagnosis-related claims.

The majority of ENT claims are associated with care provided in an ambulatory surgery center setting. However, inpatient surgical treatment cases tend to have worse patient outcomes, are more expensive, and are much more likely to involve communication breakdowns across specialties and nursing staff.

Communication breakdowns between ENT surgeons and their patients/caregivers most often are related to informed consent. Adherence to a well-defined informed consent process is critically important and may ultimately affect patient satisfaction, as informed patients are more likely to take an active role in their care.

Insufficient documentation most often is noted in allegations of improper surgical treatment. Thorough and concise documentation to support the clinical rationale for treatment decisions and diagnoses is crucial. Failure to document the informed consent discussion is often a differentiating factor, and is frequently paired with lack of inadequate informed consent. Additionally, clear written and verbal instructions related to treatment plans and follow-up care can help avoid issues with patient noncompliance.
A NOTE ABOUT MEDPRO GROUP DATA

MedPro Group has entered into a partnership with CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions. Using CRICO’s sophisticated coding taxonomy to code claims data, MedPro Group is better able to identify clinical areas of risk vulnerability. All data in this report represent a snapshot of MedPro Group’s experience with emergency medicine claims, including an analysis of risk factors that drive these claims.

DISCLAIMER

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