Management of Bariatric Surgery Patients

Bariatric surgeries inherently have additional risks due in part to patient co-morbidities and the necessity for patients to be active participants in their plan of care post-operatively. Bariatric claims are not as frequently noted in our data as other surgical specialty claims; however, when they do occur, we note some distinct differences, not the least of which is a 25% higher rate of clinically severe injuries than the average of other surgeries.

Bariatric cases are more often about the post-operative management of the patient than the actual performance of surgery (although some involve both issues). These management cases tend to result in the most serious outcomes, and include patients who developed surgical complications such as pulmonary emboli and infections. Management of the post-op course is often complicated by the surgeon’s delay in recognizing and then reacting to complications such as bowel perforations. Bariatric patient deaths were more common in this patient population than other surgical patients (32% bariatrics; 13% other surgeries). The majority of these deaths were attributed to the surgical management cases.

Figure 1. Top Surgical Allegations

![Figure 1. Top Surgical Allegations](image)
More than three-fourths of bariatric claims arose in the inpatient setting (OR, patient rooms). There were a few ambulatory surgery center cases noted; most of them involved laparoscopic gastric band placement with bowel perforations, lacerations and slippage of the band. Most of the complications were noted immediately and repaired.

**Risk Factors**

The distribution of risk factors - complex issues which impact the patient’s outcome - are, at a high level, similar across all surgical specialties. Issues like surgical skill competency, surgical care team communication breakdowns, and non-compliant patient behavior are routinely seen across all specialties.

Where we start to see some distinct differences, however, are in clinical decision-making, the process for patient care, and informed consent discussions. Keep in mind that it is often the intersection of several factors which contribute to a non-desired outcome.

**Figure 2. Top Differences in Risk Factors**

Aside from surgical competency and decisions about which procedure type best suits the patient, the most frequently noted risk factor in bariatric claims is the failure to recognize and react to the significance of developing symptoms or diagnostic test results.
Case Examples: Recognizing & Reacting to Complications

- The patient’s pain level was noted to be 6/10 on post-op day one following a laparoscopic Roux-En-Y bypass. An upper GI revealed some obstruction at the gastro-jejunal junction, but there was no concern of leakage outside the gastric pouch. She was treated with pain medications over the next 24 hours with only occasional relief. Her family reported that she felt warm. Examination by the surgeon resulted in prescription of additional pain medications. A few hours after that evaluation, she developed shortness of breath. Diagnostic testing, including a STAT chest CT with pulmonary emboli protocol was ordered, but the CT was not completed until 5 hours later. Results suggested a bowel perforation. Emergent surgery was performed, but the patient developed septic shock and died. Cause of death was attributed to perforation of the gastric remnant and delayed recognition of that perforation. The case was settled.

- An 18-year old patient was discharged to home on post-op day two following Roux-En-Y gastric bypass. During a follow-up call two days later from the surgeon’s nurse practitioner, chart documentation noted that she reported nausea and bloating, and was prescribed medications for these complaints. Her family stated that she also reported persistent retching and hiccups, but there was no documentation in the chart to show whether the patient was asked about additional symptoms. The next day, the patient was found dead. Autopsy results revealed a complete rupture of the anastomosis. Allegations of negligently performed surgery and failure to recognize the signs and symptoms of a post-operative rupture was made, and the case was settled.

Clinical systems issues encompass breakdowns in the process for safe patient care. This factor includes scenarios when there are multiple providers involved in post-operative decision-making; failure to designate the provider in charge - be it the surgeon or the medical specialty physician - can lead to compromised treatment. Furthermore, failures of nursing staff to notify surgeons of situations such as non-response to post-op pain control, repeated patient complaints about discomfort, and changing vital signs were more common in the bariatric claims. Of note, in our data, nursing staff are noted more often as non-primary contributing responsible providers to the outcome of bariatric cases than they are in other surgical cases (14% bariatrics; 7% other surgeries). This suggests that in these cases, better
working relationships between the surgeon and the nurses could potentially have avoided the adverse event that led to the claim(s).

**Case Example: Process of Care Failures**

- Intra-operative complications arose during a gastric bypass surgery, including a leak at the esophageal anastomosis requiring conversion to an open procedure, and a prolonged hypotensive episode. The patient was in the supine position for the entire 11-hour procedure, and initially complained of buttock pain while in the recovery area. The surgeon was not notified and the patient was admitted to the floor just 90 minutes after surgery ended. Pulmonary and internal medicine consults were ordered, but those physicians did not round on the patient until the next day. Upon arrival to the floor, the patient complained again of buttock pain and also nausea. Nausea was reported to the surgeon, but the pain was not. On post-op day one, low renal functions were noted, as was an elevated WBC, a temp of 101.3 and no passage of urine. The surgeon ordered a nephrology consult after almost 12 hours of progressing symptoms, but nephrology didn’t see the patient until the next day. On post-op day 2, a concern for rhabdomyolysis was raised due to positioning on the surgical table, but the patient was not worked up any further to explore that concern. Over the next 2 days, she became confused, tachycardic, and was noted to have elevated CPK/Troponin levels. On post-op day 4, the patient was returned to surgery wherein an abscess was discovered in the supramesocolic region, but the patient did not survive the surgery. Autopsy results revealed focal necrosis and extensive autolysis. The case was settled due to the convergence of multiple clinical system failures.

Some significant differences between bariatric claims and other surgical claims exist also in terms of informed consent. Of course the actual process of obtaining informed consent doesn’t affect the clinical outcome of the patient, but it can - and often does - influence whether patients file a malpractice claim and it absolutely can have a deciding influence on the resolution of that claim. Failing to engage in a robust informed consent discussion (including other treatment options and possible additional surgeries), failure to paint a realistic picture of the expected outcomes, and failure to note all of this discussion in the patient’s chart can influence the resolution of the case.
Case Example: Lack of Informed Consent

- A very large hiatal hernia was discovered during performance of a gastric sleeve resection. The bariatric surgeon made the decision to reduce the hernia, but did not seek intra-operative consent from the patient’s spouse who was in the hospital’s waiting area. During the procedure, a perforation of the esophagus occurred. Repair was unsuccessful with leaks noted, and a gastroenterologist was called in to perform an EGD and stent placement. Post-operatively the patient continued to have complications and was returned to the OR nine times in an attempt to repair the leak (stents were too small in diameter, then not long enough, then migrated into the peritoneum via the esophageal perforation). Infection, then sepsis, developed and the patient endured a stormy course of recovery. Perforation is a known complication of hiatal hernia repair, but the patient did not consent to that procedure to be performed during the bariatric procedure, nor were she or her spouse informed of the possibility of other procedures which might need to be performed. This lack of consent was a major reason for settlement of the case.

Resources

- MedPro Group: Reducing Bariatric Surgery Risk
- JAMA Network: Variation in Outcomes at Bariatric Surgery Centers of Excellence
- Checklist: Informed Consent

Data Source

MedPro Group closed claims data, 2008-2017