Trauma Claims: Team & Patient Management

Trauma surgeons see the most seriously injured patients in situations that are intense and demanding. These critically injured patients often require multiple surgeries with coordination among multi-specialty surgeons and physicians, and they can have long recovery periods. As we look at claims against trauma surgeons though, we see that they are not all about surgical performance. Rather, post-operative care and missed diagnoses are important claims drivers as well. Of the allegations against trauma surgeons, surgical treatment only represents about half the total.

Allegation Categories

- Surgical treatment
- Diagnosis-related
- Medical treatment
- Other*

In addition, within the surgical allegation category, more than half involve management of the surgical patient, rather than the surgical technique (much more common in other surgical specialties). Further, only half of
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The surgical allegations occurred in the operating room or recovery unit, reflective of how post-operative patient management issues are frequently noted in the ICU/patient room setting.

Across all allegations, only 22% occurred in the OR suite/recovery area; the other three-fourths of the claims arose in inpatient units or the emergency department.

The majority of the claims arising in the emergency department are prior to any surgical intervention and most frequently involve missed fractures (in part because the fractures are generally minor compared to the other injuries), but also include other traumatic injuries and even incidental findings of disease. Post-surgery patient decompensation represents the largest category of issues faced by trauma surgeons.

Risk Factors

The associated risk management issues, or risk factors, align with claims frequency involving management of the surgical patient versus technical performance of surgery. Clinical judgment factors, which are most prevalent in the trauma claims, involve a narrow diagnostic focus and reduced or delayed response to a patient’s repeated complaints. Clinical systems issues reflect delays in reporting findings or a failure to definitively identify the providers who are coordinating care; these are indicative of patient process of care/patient management breakdowns. Clinical environment represents the hectic nature and complexity of care.
While communication issue frequency appears to be similar to that of other surgeons, the underlying makeup of the communication breakdowns is quite different. The required coordination of care in trauma settings is reflected in the high frequency of provider to provider communication issues not normally seen in other surgery claims.

**Take Home Points**

Unlike other surgeons’ claims experiences, it is the management of the patient and the coordination of the healthcare team that matters most in the claims related to trauma surgeons, rather than the surgery itself. Coordination of care and management of a team of clinicians who can contribute to the safety of patient care is essential for the trauma surgeon. Risk strategies include:
• Look again at the patient following initial care and recovery to ensure other injuries are not missed.
• Be aware that a diagnostic focus can be narrow.
• Follow-up on all patient complaints, particularly those that are repeated.
• Ensure that the provider coordinating ALL care is identified clearly, and upfront.
• Develop a mechanism to ensure that the communication between providers, including nursing, is ongoing and timely to prevent non-relayed findings which may be critically important; documentation of this communication is critical.
• Be especially diligent about surgical counts; retained foreign bodies can happen more easily in a hectic environment and in patients with significant blood loss.

Case Illustration
A patient presented to the Emergency Department having suffered blunt head and thorax trauma from a fall onto concrete. Her medical history was significant for sleep apnea, obesity, cardiovascular disease and diabetes. A spinal CT revealed fractures at C1-2. A fractured left wrist was also noted. She was admitted to the trauma service and cleared for surgery (reduction of wrist fracture by orthopedic surgeon and stabilization of the spine by neurosurgeon). She was recovered in the ICU, not PACU, due to it being the weekend. Recovery nursing staff documented patient agitation on arrival to ICU; morphine was given twice per anesthesia orders. Patient care was then transferred to the ICU nurse, although an Aldrete score was 7; hospital policy and anesthesia orders required an Aldrete score of 8 prior to release from post-op recovery care. The trauma surgeon was notified twice (but no documentation was made in the chart as to the time) of the patient’s increasing agitation. The ICU nurse documented a phone order from the trauma surgeon for 1mg Ativan (may repeat one time). Two doses were given within 30 minutes, and within 15 minutes of the second dose, the patient crashed - prior to the arrival of the trauma surgeon. A head CT showed a hypoxic brain injury. The patient remained in a vegetative state until her death two years later. Retrospectively, criticism was leveled against the trauma
surgeon for failure to be onsite in a timely manner and for the Ativan order. In addition, there was no ICU nursing documentation of clinical findings from the time care was transferred to the ICU staff until the patient crashed (40 minutes).

**Data Source**

MedPro Group closed claims data, 2007-2016

*Other = claims for which no significant volume exists

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