

How to Avoid Malpractice Suits in Bariatric Surgery

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ACS Claims Study 2003-2004

- Charge of negligence not bariatric specific.
- Patient outcomes were graded using the National Association of Insurance Commissioners 10 point scale (0 = no obvious injury and 9=death). 70% of patients were over 40 y/o and 3/5 were women.
- The most common comorbidity was obesity, followed by smoking, hypertension and diabetes and 76% were ASA Class 1 or 2 (relatively healthy).
- 22% of patients preoperative care was considered deficient (28% in cases resulting in a fatal injury).
- The surgeon reviewers identified cases in which comorbid conditions could have led to earlier treatment.
 - In 31% post-operative care was considered deficient (36% in cases resulting in a fatal injury).
 - Only 12% were considered deficient due to a technical problem at time of the actual operation. ⁽⁴⁾

100 malpractice claims against bariatric surgeons

- In a focused review of 100 lawsuits of bariatric surgery claims (not yet adjudicated)
- 45% were evaluated for defense attorneys
- surgeon experience showed 42% had less than one year of experience (26% had done <100 cases)
- 69% were members of the American Society for Metabolic and Bariatric Surgery
- Only 22% had comprehensive consent forms.

	Leak	Abscess	Obstruction	Airway	Organ Injury	DVT/PE
%	52%	33%	18%	10%	10%	8%
Allegation	Delay in Diagnosis 60%	Delay in Diagnosis 60%	Delay in Diagnosis 61%	Occur with adverse event	90% require re-operation	50% had BMI of >60
Exp of Surgeon	54% <1 year exp	Identified 12 days (average) after surgery	Identified 6.3 days (average) after surgery		80% > 100 cases	Identified at 8 days on average
Death	60%	58%	39%	70%	30%	88%

Cottam D et al. Medico legal analysis of 100 malpractice claims against bariatric surgeons. Surg Obes Relat Dis 2007;3:60-67.

100 malpractice claims against bariatric surgeons

- In 28 of 100 cases potential negligence was found
 - 82% were due to delay in diagnosis
 - 64% involved cases of misinterpreted vital signs
 - Technical error in performance of the operation constituted only 8% of cases.
- The hospital was named as a co-defendant in 45% of the cases
- In 15% of cases an error occurred in management shortly after a covering surgeon took over care of the patient.

Malpractice Claims Analysis 2010

- The most prevalent is in the broad category of post-operative management.
- Failure to diagnose a post-operative leak is the leading allegation, followed by failure to diagnose and treat a PE/DVT, and then failure to appropriately diagnose and treat post-operative malnutrition/vitamin deficiencies.
- Other allegations involving discharge of the patient without identifying significant post-operative symptoms and treating the same, the management plan itself, follow up on lab testing and results, and alleged delays in taking a patient to the OR post-operatively.

Stevens and Lee,
2010 Claims Analysis in Malpractice
Carrier

Malpractice Claims Analysis-2010

- Significant drivers that lead patients to file bariatric surgery claims include:
 - Expensive medical bills from long-term, post-operative care
 - Patient deaths
 - Lack of trusting physician-patient relationship (for any number of reasons, including surgeon demeanor, office customer service, and unmet expectations)

Stevens and Lee, 2010

Claims reported by a Malpractice Carrier

Affect of Increasing BMI on GS Claims

We hypothesized that the increasing body mass index of the population has affected general surgery malpractice claims

- **METHODS:**

- Physician Insurers Association of America database from 1990 to 1999 (ie, period 1) and 2000 to 2009 (ie, period 2) for claims associated with obesity and morbid obesity
- Analyzed the error involved, injury severity, procedure, and outcome.

- **RESULTS:**

- Five hundred seventy-five claims were identified
- The percentage of paid claims **did not** differ by body mass index.
- Improper performance was the most common alleged error
- Gastric bypass was the most common procedure
- Death was the most common injury
- For obesity claims, the case was more likely to be settled in period 1 and withdrawn/dismissed in period 2 ($P < .001$).
- The number of morbid obesity claims rose from 9 in period 1 to 249 in period 2.

- **CONCLUSIONS:**

- The significant rise in morbid obesity claims between periods is likely caused by the substantial increase in the number of bariatric procedures performed.

Am J Surg. 2013 Mar;205(3):293-7. doi: 10.1016/j.amjsurg.2012.10.023. Epub 2013 Jan 17.

Comparing 20 years of national general surgery malpractice claims data: obesity versus morbid obesity.

Weber CE, Talbot LJ, Geller JM, Kuo MC, Wai PY, Kuo PC.

Source Department of Surgery, Loyola University Medical Center, 2160 S First Ave, Maywood, IL 60153, USA.

Informed Consent

- Is a process not just a piece of paper
- Public Education Seminar
- Support Group attendance
- On Line Chat/message boards
- Commercial Web Sites
- Psychological Evaluation
- Surgeon Consultation
- Written consent and testing for comprehension

Impact of Preoperative Teaching on Surgical Procedure Chosen by the Patient

	Uncertain	AGB	RYGBP
Before Teaching	23%	34%	43%
After Teaching	1% (3)	20%	70%
After Teaching	15%(45) changed their surgical option	9%(27) declined to have surgery	

Conclusion: Preoperative teaching provides an informed and better patient selection

Direct to Consumer Advertising

Giusti V et al. Impact of preoperative Teaching on Surgical Option of Patients Qualifying for Bariatric Surgery Obesity Surgery (2004) 14:1241-1246.

Content

- Provide Realistic Risk Estimates that include patient factors and institutional and health provider characteristics (experience and outcomes).
- Discuss short- and long-term risks and complications and the potential for unknown or unforeseeable long-term risks

Benefits/Effectiveness

- Provide realistic estimates of short and long-term weight loss, including the potential for weight regain and modest benefits
- Inform them if long-term data (>5 years) are unavailable
- Advise patients on the long-term health benefits of weight loss produced by WLS category

Benefits/Effectiveness

- Make them aware that not all preexisting medical and psychosocial consequences of obesity, including eating disorders, will improve with WLS
- Give realistic estimates for health outcomes if patients decline surgical treatment and advise them of known factors and interventions that might optimize benefits

Benefits/Effectiveness

- Consider patient expectations, the value placed on different outcomes, and the risks each candidate is willing to accept: address unrealistic expectations or other misconceptions patients might have

Consequences

- Advise patients on required behavioral and dietary changes and other reasonable and foreseeable consequences of WLS that could affect health or quality of life in a substantive way e.g. gastrointestinal symptoms, cosmetic effects, nutritional restrictions

Alternative treatments

- Advise patients about alternative WLS procedures and nonsurgical treatment options (e.g. medical and behavioral)
- Inform them about alternatives even if they are not available through the consenting health provider or institution

Comprehension of informed consent

- Evaluate each patient's comprehension of the risks, benefits, consequences and alternatives to WLS
- Confirm comprehension to protect patients engaged in the informed consent process

[American Society of Metabolic and **Bariatric Surgery** patient safety committee policy statement on the qualifications of expert witnesses in **bariatric surgery** medicolegal matters.](#)

Dallal RM, Cottam DR, Bertha N, Bonanni FB Jr, Bour ES, Brolin RE, Kim K, Petrick A, Sweet WA, Blackstone RP; ASMBS Patient Safety Committee and Executive Committee. Surg Obes Relat Dis. 2012 Mar-Apr;8(2):e9-10. doi: 10.1016/j.soard.2011.12.002. Epub 2011 Dec 11. No abstract available.

ASMBS Recommendations: Expert Witness

- 1. Members should be **encouraged to serve as expert witnesses, for plaintiffs as well as defendants.**
- 2. A member serving as an expert witness should not be an advocate or a partisan but should champion what is believed to be the truth. The expert should review the available medical information in the case and testify as to its content fairly and impartially.
- 3. A member serving as an expert must show **demonstrated competence by experience in the specific area of bariatric surgery** at issue in the legal proceedings.

ASMBS Recommendations: Expert Witness

- 4. Expert testimony should reflect the opinions of the expert and also describe where such opinions may vary from common practice. The **expert should be prepared to state the basis of the testimony presented and whether it is based on personal experience, specific clinical references, or generally accepted opinion in the field.** The expert should not present his or her opinions as the only correct opinions if they differ from what other bariatric surgeons might do under similar circumstances. Important alternate methods and views should be fairly presented and discussed.
- 5. An expert should be **engaged in the active practice of bariatric surgery** or have been engaged in the active practice of bariatric surgery at the time of the alleged incident at issue in the legal proceedings. The expert should review the standards of practice prevailing at the time of the alleged incident.

ASMBS Recommendations: Expert Witness

- 6. A member's compensation as an expert witness should not be based on the content of his or her testimony or on the outcome of the legal proceedings. The compensation of the expert witness should be reasonable and commensurate with the time and effort given in analysis and preparation for testimony.
- 7. The expert witness should be aware that transcripts of deposition and courtroom testimony under oath are public records and are subject to peer review

Medical Tourism

- Obese patients are driven to seek care outside the US because they lack benefits for care in the US
- Some US surgeons are going across borders to operate
- Most patients have no aftercare and are coming to ED without insurance for treatment of complications
- ASMBS has issued a statement about the obligation of members to care for ED patients

Who is vulnerable?

- Poor Patient Experience HCAPS scores
- One type of procedure
- No medical/behavioral approach
- Refusal to see patients in consultation or in ED
- Refusal to accept patients from other institutions with a lower level of expertise
- May be vulnerable for cost of complications
- May be accountable for poor outcomes of other surgeons – we are all in this together now
- Poor handoff between you and partners (especially if GS)
- No actual expert in MBS available

Summary

- Few claims are based on performance in the OR
- Most claims reflect aftercare issues
- Expert witness should be a practicing bariatric surgeon
- Informed consent is critical to the patient's care
- Watch out for controllable land mines

THANK YOU