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CME: CARING FOR VULNERABLE PATIENT POPULATIONS

Also in this issue:

- **Closed claim: Wrong-site surgery of the spine**
- **Closed claim: Unnecessary surgery and patient death**

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CME - CARING FOR VULNERABLE PATIENT POPULATIONS

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OBJECTIVES

Upon conclusion of this course, the physician will be able to:

1. list the determinants of health that can affect or create vulnerable patient populations;
2. describe special considerations physicians must take when treating elderly patients;
3. recognize the importance of cultural competency and the unique challenges of minority patients; and
4. discuss the importance of health literacy when treating vulnerable patients.

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DISCLOSURE

Ariana Gutierrez and Wayne Wenske have no relevant relationship(s) with ineligible companies to disclose related to this activity. TMLT staff, planners, and reviewers have no relevant relationship(s) with ineligible companies to disclose related to this activity.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in practical ways to improve vulnerable patient outcomes and increase patient safety.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

PRICING

The following fee will be charged when accessing this CME course online at https://lonestara.inreachce.com.

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ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

TEST

To receive credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

INSTRUCTIONS

the Reporter CME test and evaluation forms must be completed online. After reading the article, go to http://lonestara.inreachce.com. Follow the online instructions to complete the forms and download your certificate.

Questions about the CME course? Please call TMLT Risk Management at 800-580-8658.

ESTIMATED TIME TO COMPLETE ACTIVITY

It should take approximately 1 hour to complete this activity.

RELEASE/REVIEW DATE

This activity is released on August 8, 2022 and will expire on August 8, 2025.

Please note that this CME activity does not meet Lone Star Alliance RRG's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

According to the Centers for Disease Control and Prevention (CDC), "vulnerable populations" in a health care setting are defined as "anyone who has difficulty communicating, has difficulty accessing medical care, may need help maintaining independence, requires constant supervision, or may need help accessing transportation." [1]

Vulnerable populations such as the elderly, minority communities,[2] low-income communities, unhoused individuals, LGBTQ+ people, and the chronically ill or disabled are among those that face the most difficulty when accessing health care. Many patients may fall into two or more of these social categories.

These patients are commonly at higher risk for medical errors, complications, and lesser quality of care. It is important for physicians to recognize the characteristics and determinants of health in these populations. A thorough understanding of these vulnerable patient populations can help reduce disparities and strive toward more equitable access to care.

DETERMINANTS OF HEALTH

The following range of personal, social, economic, and environmental factors that influence a patient's health status are known as "determinants of health." [3]

Economic

Economic status is considered a determinant of health because without money, people's access to quality care and services is compromised. In the United States, one in every 10 people lives in poverty [4], with most being unable

to afford healthy foods, stable housing, prescriptions, and other needs that contribute to a person's health status. A person's economic status has a direct impact on their overall health due to the high costs that accompany being "healthy." Those who are capable of working are better equipped to access healthy options. Unfortunately, those who do not have the ability to work have very limited health care options.

Social

Social determinants of health reflect the conditions in which people are born, live, learn, work, and age. These impact a person's health, functioning, and quality-of-life outcomes. Some examples of social determinants include:

- availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthy foods;
- social norms and attitudes, such as discrimination;
- exposure to crime, violence, and social disorder in a community, such as the presence of street trash, gang activity, and public substance abuse;
- access to social support and social interactions;
- access and/or exposure to mass media (newspapers, television), the internet, or cell phones;
- socioeconomic conditions, such as concentrated poverty;
- access to quality schools;
- transportation options;
- public safety;
- residential segregation; and
- physical barriers to access for those with disabilities.

Quality health care and services

Many people in the U.S. do not have health insurance and even more do not have a primary care provider. Without primary care providers, these vulnerable populations often do not receive preventive care services and screenings; may unknowingly delay care for a serious illness; and are thus more likely to require emergency services. Barriers to care such as lack of availability or insurance coverage, cost, and limited language assistance can lead to unmet health needs, and more frequent hospitalization for preventable diseases.

Environmental

Location can greatly determine access to healthy options and health services. Those who live in more rural locations may need to drive many miles to access routine or emergent care. Many minority populations live in areas with high rates of pollution and unsafe drinking water, putting them at risk for illness and other health complications. There are also many people living in unsafe, violent, and high crime neighborhoods which may make it difficult to use outdoor areas for play, exercise, and work, which can reduce a person's quality of life.

Access and education

Low-income neighborhoods may have poorly funded school systems that lack the resources to offer children a quality education. High quality education leads to higher paying jobs and more opportunities later in life. A person's comprehension and cognitive ability also determines their capacity to make health driven decisions and seek care when necessary. Those without formal education or learning disabilities may not be equipped to understand health information, such as how to fill out insurance application forms or use the educational resources given to them by providers.

ELDERLY POPULATIONS

As the older adult population continues to grow in the U.S., there is growing concern about how to meet the needs of this group. Elderly patients are considered a vulnerable population due to a multitude of potential challenges, such as mobility and access to care, cognitive and physical health, and worsening chronic conditions. Physicians working with this population must be able to recognize areas of vulnerability and assist patients to ensure safe and accessible care.

Polypharmacy

Polypharmacy can be a concern for this population due to metabolic changes and reduced drug clearance associated with aging. Elderly patients also tend to take more medications; multiple prescriptions can be hard to afford, track, and manage. Polypharmacy can also lead to a "prescription cascade" when drug interactions cause many non-specific side effects that can lead to a misdiagnosis of a new disease, resulting in further treatments and prescriptions. Unfortunately, symptoms of polypharmacy can also present as signs of aging such as confusion, weakness, tremors, sleepiness, etc.

Comprehensive medication review and reconciliation at each visit, asking clarifying questions about prescription and non-prescription medications, and introducing new drugs one at a time and at lower doses are ways to reduce the risk of adverse drug reactions (ADRs). Leveraging pharmacists and screening tools as resources can help to prevent ADRs and improve outcomes.

Non-compliance

The U.S. Department of Health and Human Services estimates that roughly 55 percent of elderly patients are non-compliant with medications.[5] Understanding the reason for non-compliance is an essential part of the assessment process. A few common reasons for non-compliance and non-adherence are:

- cost and affordability;
- lack of understanding;
- memory loss (forgetting to take medications);
- swallowing problems;

- drug or alcohol dependence;
- social isolation; and
- difficulty managing treatment regimen.[5]

Rephrasing questions about compliance can alleviate any feelings of guilt or wrongdoing patients may experience. Examples of these questions include the following.

- Are there any barriers keeping you from getting your medication? Do you have problems getting to the pharmacy?
- Are you having side effects that worry you and keep you from taking the medication?
- How often do you miss a dose?
- Do you have someone to help you manage your drug regimen/treatment plan?
- How do you get to and from your appointments?

Elderly patients may not have the support needed to manage their care. Loss of independence can be a difficult aspect for aging adults. Patients who struggle with memory, hearing, or mobility should be encouraged to bring someone to their appointments who can assist them in managing care. Family participation can lead to better outcomes and improve adherence to treatment.

Consider assessing the mental capacity of at-risk, elderly patients at appointments to ensure they are still able to make sound decisions for their health.

Patient education

Aging patients may require multiple communication methods and more repetition to fully understand new information. As a backup to oral instructions, offer patients written instructions and materials. Longer face-to-face conversations with a staff member about a medication, treatment, or diagnosis may also be necessary.

Age-related risks

Elderly patients are at higher risk for falls. Weakness, polypharmacy, memory loss, and illness-related confusion can all lead to falls. Physicians can facilitate safer mobility for their elder patients by:

- asking patients about their mobility at every encounter;
- advising them to make safe changes to their living spaces, such as removing carpeting that can cause tripping, using a shower chair when bathing, installing handrails around the house, or using mobility devices such as canes, walkers, or scooters; and
- ordering occupational therapy assessments for the patient's home.

Documentation

Documentation is an important component of health care for all patient populations. Here are a few steps physicians can take to ensure quality continuity of care.

- Review previous encounter notes before appointments to ensure that all issues and concerns are addressed.
- Ask clarifying questions regarding previous complaints to see if the current treatment plan is effective or if the issues have been resolved.
- Review past assessments to help identify changes in a patient's condition that may be concerning and alert the care team that something may be wrong before it becomes an emergency.
- Follow up on the efficacy of newer prescriptions by asking patients how they feel after starting a new drug, if they feel their condition has improved, and if there are any new side effects.

CULTURAL COMPETENCE AND TREATING MINORITY POPULATIONS

Cultural competency: Bias, stereotyping, and racism

While disparities in health care are often the result of social determinants, physicians and other health care professionals have a powerful tool at their disposal to help combat these disparities: the cultivation of cultural competence in their office, practice, or group. Cultural competence addresses the disparities that people of racially and culturally diverse backgrounds often experience, and as our population becomes more diverse, the importance of cultural competence will grow. Becoming more aware of differences and taking action to increase cultural competency helps to ensure all patients get the care they need to live healthier lives.

According to the American Hospital Association, cultural competency in health care "describes the ability to provide care to patients with diverse values, beliefs, and behaviors, including tailoring health care delivery to meet patients' social, cultural, and linguistic needs."[6] "Cultural competency is not merely about being respectful of a person's cultural background, religious beliefs, or language proficiency, it is also about ensuring that cultural bias does not affect your personal interactions.

Having a cultural bias is when one assumes that one's own culture is what is accepted as 'normal' and shared by everyone. For example, a cultural bias may be that Americans typically eat such foods as eggs, bacon, cereal, and toast for breakfast. But what about the people in America who eat noodles for breakfast? Or tortillas? Or hummus? Or any of the other myriad foods eaten for breakfast all over the world? Are they not normal?"[7]

Often, these biases are unconscious and triggered without an individual's awareness or control. Unconscious bias (or implicit bias) is usually defined as an unsupported, subconscious assumption, belief, or attitude in favor of or against a thing, person, or group compared to another. This bias may be favorable or unfavorable, and many

unconscious biases are exhibited toward minority groups based on factors such as class, gender, sexual orientation, race, ethnicity, nationality, religious beliefs, age, or disability.[8]

An individual can get into the habit — consciously or not — of only recognizing traits in groups or individuals that reinforce their bias, usually an unfair reinforcement. Such as, "all older people are uncomfortable with new technology" or "all younger people have short attention spans" or "men are less empathetic than women."

Having and reinforcing an unconscious bias can lead to the creation of a stereotype. When biases are routinely used or reinforced without examination or awareness, that bias can become an over-simplification of an entire group of people — and a stereotype can result.

Unfortunately, stereotypes have plagued American society for generations, with research suggesting that Blacks and non-White Hispanics are viewed more negatively by Whites than other minorities such as Asians. These biases not only have damaging effects for these populations in daily life, but also on the medical care they receive.[9]

Physicians and health care providers are human and not immune to bias. However, awareness of cultural differences can go a long way toward battling cultural bias. In the health care environment, cultural biases can lead to poor communication, a lack of understanding, and patients withdrawing from their physicians out of fear of being misunderstood, disrespected, stereotyped, or looked down upon.[10]

Cultural bias can also lead to incorrect diagnosis and treatment and lack of continuity of care. On the other hand, patients who feel their physicians are respectful of them as individuals and of their backgrounds are more likely to be compliant with treatment. Ensuring consistency and equity of care to patients should be a top priority when treating minority populations.[10]

Access to care

Racial and ethnic minorities face unique challenges when attempting to access health care in the United States. Hispanics, Blacks, and Asians may have lower levels of health insurance coverage compared to their White counterparts. Of these populations, Hispanics have the most difficult time accessing coverage. In part, this is due to these populations more frequently working in jobs that do not offer private employer insurance coverage.[11]

Hispanics and Blacks are also more likely to receive care in settings such as a hospital's emergency department or at a stand-alone clinic.[9] It can be difficult for these patients to access preventative care, and they may not maintain quality continuity of care due to seeing multiple providers.

The federal Medicare program was created to assist patients (specifically elderly patients) in accessing care and reducing financial barriers to health care. Unfortunately, Medicare does not provide coverage for all health care needs and can lead to out-of-pocket expenses that many patients cannot afford.

SPECIALTY-SPECIFIC CONSIDERATIONS

Societal and intuitional biases, stereotyping, and racism can cause great harm to minority patients in certain areas of health care. Special considerations exist in the areas of pain management, cardiology, dermatology, and maternal medicine. Physicians in these specialties should consider taking a few extra steps to help these patients feel more personally supported.

Steps to building trust and a more supportive environment for patients include:

- speaking in a clear and friendly manner;
- maintaining eye contact;
- using plain language and avoiding the use of medical jargon;
- offering translation services, if language barriers exist;
- adapting your pace so the patient does not feel rushed; and
- educating and encouraging your staff members to be aware of their own behaviors and responsiveness to patients' needs.

Pain management

Ethnic and racial minorities are overrepresented among those who experience pain. Studies have demonstrated that patients of color are more often viewed as "drug seeking" when reporting pain and may receive less adequate treatment for acute and chronic pain.[12]

Minority patients also frequently underreport pain due to the cultural adoption of stoicism. Broad stereotyping exists that Black, Hispanic, Middle Eastern, and Mediterranean patients react more expressively to pain than White or Asian patients. However, these minority groups often adopt more stoic demeanors to fight this stereotype, remain objective, and become empowered in the face of potential discrimination.[13]

Physicians should encourage patients to accurately report pain intensity while combating any internal or external bias regarding pain management and patients of color. Holding unconscious stereotypes of patients regarding pain can be harmful and perpetuate negative stereotypes.

Cardiology

Studies have shown that people of color, specifically Black patients, are at a higher risk of hypertension, depression, and coronary artery stenosis. This risk is often

associated with the cumulative burden of living with the chronic stress, physical and mental "wear and tear," and environmental challenges of being a minority in a racist or discriminatory society. These challenges are also felt by other minority groups and can adversely affect a patient before they even seek care.[14]

Dermatology

Skin disorders and rashes are commonly misdiagnosed or undertreated due to the lack of representation of people of color, i.e., different skin colors, tones, and types, in dermatology textbooks. This issue can lead to improper or misdiagnosis for people of color. This is not to fault dermatologists, but a system in which White skin tones are overrepresented when educating on skin conditions.[15]

A study of general medicine textbooks found that only 4.5 percent showed images of dark skin.[15] This unconscious bias negatively affects the ability to accurately diagnose and treat patients with deeper skin tones and may keep patients from receiving proper care. For physicians in these circumstances, educating oneself on how various rashes and skin conditions present on darker skin tones greatly increases the ability to accurately diagnose patients of color.

Maternal medicine

According to a 2020 report by the CDC, maternal mortality rates for non-Hispanic Black women (55.3 deaths per 100,000 live births) was 2.9 times higher than non-Hispanic White women (19.1 deaths per 100,000 live births). Hispanic women experienced 18.2 deaths per 100,000 live births.[16]

The World Health Organization defines maternal mortality, or maternal death, as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[16]

Disparities in pregnancy-related deaths also increase with maternal age. Black and American Indian and Alaska Native (AIAN) women between 30-34 years of age have a mortality rate almost 4 times higher than their White and Asian counterparts.[17]

Multiple reasons exist for these disparities, many are among the social determinants of health discussed, such as access to care and economic, social, and environmental barriers. Hypertensive disorders, depression, and other chronic conditions are also associated with structural and systemic racism.[17]

To combat these biases and stereotypes, physicians in maternal medicine can work to address unconscious bias in their work environments and among their peers. They can even assist in changing policies that are harmful to minority populations. Physicians can help reduce maternal mortality rates by actively engaging with their peers and

patients to discuss how to improve the quality of care in their communities for the most at-risk patients.

Maternal medicine providers can help improve outcomes for their minority patients by:

- asking questions to gain more insight and context into a patient's life and environment that may affect their pregnancy;
- helping patients and their families understand urgent maternal warning signs and when to seek emergency care; and
- helping patients manage chronic conditions that may arise during pregnancy such as hypertension, diabetes, or depression.[18]

BIAS REDUCTION STRATEGIES

A 2012 study using psychology students as participants found that a multifaceted approach to reducing unconscious bias was successful in producing enduring reductions in bias. The following five strategies were found to be effective in combatting bias when used individually or in combinations.

1. **Stereotype replacement** — Recognize that stereotypes against an individual or group exist and replace them with non-stereotypical responses.
2. **Counter stereotypic imaging** — Think about someone from a marginalized group that does not fulfill common stereotypes.
3. **Individuation** — Focus on the individual characteristics of a person instead of their group-based characteristics.
4. **Perspective taking** — Consciously observe a situation from the perspective of another marginalized group.
5. **Increase opportunities for contact** — Seek out opportunities to engage with individuals from marginalized groups. Increased contact can help reduce bias by providing more opportunities to individuate members of the group and learn first-hand about a group's challenges.[19]

These five strategies can help improve the ability to reduce unconscious bias in a health care setting and promote equal care to all patients.

COMMUNICATION, HEALTH LITERACY, AND FEDERAL LAW

The U.S. Department of Health and Human Services (HHS) describes the Civil Rights Act of 1964, Title VI as prohibiting "discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance." This includes any direct or indirect discriminatory effect regarding services, procedures, or methods of administration – including communication.[20]

The U.S. Human Resources and Services Administration defines "health literacy" as "the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions."

They also describe groups with lower health literacy as being "older adults, minority populations, low socioeconomic status, and medically underserved people."[21] A patient's ability to understand their health conditions and treatment options vastly improves their adherence to treatment and to recognize improvements or side effects to newly prescribed medications.

A few reasons a patient may not be able to fully grasp their medical concerns could be limited English proficiency (LEP), poor cognition, or low education skills. These patients may have difficulty locating providers, filling out health forms, understanding medication instructions, or managing their chronic conditions.

Be mindful of a patient's health literacy when discussing care. When necessary, use interpreters and other methods of education to help ensure competent decision-making by the patient. Physicians can further help by:

- using non-complex language and shorter sentences;
- defining technical terms;
- supplementing instruction with appropriate materials, such as videos, pictures, graphics, etc.;
- asking patients to explain your instructions back to you (teach back method) or to demonstrate an at-home procedure for you;
- asking open-ended questions that begin with "how" and "what," rather than yes/no questions;
- organizing information so that the most important points stand out; repeat this information as often as necessary;
- providing LEP patients with information in their primary language; and offering help with completing forms.[21]

According to the Civil Rights Act of 1964, recipients of federal funds, such as Medicaid or Medicare reimbursements, must take reasonable steps to make their programs, services, and activities accessible by eligible persons with LEP. Interpreters can help improve patients' understanding of care. When using an interpreter, it is important to:

- greet the patient first, then the interpreter;
- speak to the patient directly throughout the encounter;
- speak at an even pace and use pauses to allow the interpreter time to interpret effectively;
- ask one question at a time;
- pay attention to the patient's body language;
- speak in plain English, try not to use slang or overcomplicated medical terms or jargon;

- introduce yourself to the patient with your title, specialty, and why you are seeing them;
- allow the interpreter time to translate, not all concepts have a direct translation and may take longer to explain;
- use non-verbal communication to demonstrate you are listening to the patient's concerns through the interpreter, such as making eye contact, sitting closer to the patient, and using appropriate facial expressions to convey care and understanding of what the interpreter says.

IMPOVERISHED AND UNHOUSED POPULATIONS

People experiencing homelessness face enormous health inequity, including shorter life expectancy, higher morbidity, and greater use of acute health care services. Homelessness is a significant determinant of health, as a person's socioeconomic status correlates to their ability to access and receive health care.

It is common for unhoused patients to only seek medical care in emergencies because their priorities of finding food and shelter usually come before health. They are less likely to seek primary or preventive care which may result in late-stage diagnoses, poor control of manageable conditions, and increased hospitalizations for preventable conditions.

This population is also at most risk for violence, poor nutrition, lack of adequate clothing, sleep deprivation, and substance abuse. All of these factors contribute to making them more vulnerable to illness, trauma, and mental illness.[22, 23]

When discussing health concerns with this patient population, taking the necessary time to listen and build trust can greatly increase their ability to seek care before it becomes an emergency. Also, assisting these patients with social services and programs not only helps them to meet their most basic needs, but also to prioritize their health and safety.

Educate yourself and your staff on community resources that can assist patients who may be impoverished or unhoused. Seeking and using assistance from social workers and case managers can also be a very helpful way for physicians to positively affect their patients' lives.

Mental health concerns

Poor mental health is rampant in the unhoused and impoverished communities. The correlation between poverty and mental illness is a consequence of adverse social and economic conditions. Often a person with untreated mental health conditions will end up homeless or living in poverty due to their inability to cope in society. Affective disorders such as bipolar disorder, schizophrenia, anxiety, depression, and substance abuse are among the most common mental illnesses in the homeless population.[24]

Those who have mental illness may have cognitive and behavioral problems that make it challenging to carry out daily activities or create a steady income that can offer stable housing. Systemic issues such as lack of low-income housing and generational poverty can also have negative effects on a person's mental health.

Childhood poverty and abuse are traumatic events that have lasting psychological implications and often lead to chemical dependency starting in the teenage years. Mental health providers working with community outreach programs can assist unhoused and low-income patients living with mental illness to receive care outside of facilities.

LOWER INCOME PATIENTS

Physicians may have opportunities to help lower-income patients by offering sample medications or discounts from drug manufacturers. Educating patients on resources like prescription assistance programs can help patients be more compliant.

Having up-front conversations about cost when prescribing expensive medications and treatments will also aid low-income patients in accessing care. Referring to community health centers and clinics may be a way to reduce costs to patients when assistance is needed.

Patients living in poverty may also have difficulty accessing healthy foods. "Food deserts" — areas that lack access to grocery stores, farmers markets, or healthy food providers — are more common in lower income areas, making healthy food choices difficult.

Patients living in lower income neighborhoods may wish to comply with diet changes and healthier lifestyle choices but may be incapable of doing so because of their environments. When talking to these patients, ask what the food availability is like in their neighborhoods, and if they can afford healthy food. Educating them on nutrition and food assistance programs, like the Supplemental Nutrition Assistance Program (SNAP) [25] and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) [26], may help them make beneficial changes.

Patients may feel vulnerable about discussing their ability to find healthy food in their area. But having open conversations with all patients regarding their food sources can eliminate the stigma surrounding poverty and food insecurity.

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WRONG SITE SURGERY OF THE SPINE

by Wayne Wenske, Senior Marketing Strategist

PRESENTATION

On April 28, 2016, a 42-year-old man came to Neurosurgeon A on referral for neck pain with radiation to his upper arms and numbness. The patient's history included a surgery on his right hand; medications included cyclobenzaprine and meloxicam.

Neurosurgeon A reviewed an MRI scan that revealed the patient had severe compression at C5-C6 and C6-7 with effacement of his spinal cord and severe foraminal impingement. The surgeon recommended a C5-6 and C6-7 anterior discectomy and fusion.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

On May 25, 2016, Neurosurgeon A took the patient to surgery. In the operative note, the surgeon mentioned that x-rays confirmed the location at C5-6 and C6-7. Hospital records show that two fluoroscopic images, interpreted by Radiologist A, were submitted from the OR showing surgical hardware was present from C5-C7. However, another hospital record indicated that the fluoroscopic images were submitted but there was not a radiology interpretation. The surgery was completed without complications, and the patient reported that he was doing well at his first post-operative visit approximately four weeks later.

On August 11, the patient returned for a six-week-follow-up and reported pain in his lumbar spine and symptoms of radiculopathy. A lumbar MRI was ordered and showed degenerative disc disease at L5-S1 without broad-based protrusion that touched the right and left S1 nerve root without canal stenosis or significant neuroforaminal narrowing.

At an October 3 visit, Neurosurgeon A diagnosed the patient with L5 sciatica. During this visit, the physician discussed the option of a hemilaminectomy and foraminotomy. The patient agreed to the surgery and scheduled it for November 23. However, the patient cancelled the surgery on November 22.

The patient began treatment with a pain management physician who performed epidural steroid injections on June 25, 2017, and December 19, 2017. The physician documented the patient's history as including a C6-T1 fusion in May 2016. The patient reported that since the 2016 surgery, he experienced numbness, tingling, headaches, and right-sided neck pain with radiation and a right C6 distribution. A cervical MRI taken on November 2018 showed a disc bulge at C5-6 resulting in mild right foraminal narrowing.

Neurosurgeon B performed a C5-C6 fusion and removed the previously placed hardware from C6-T1. The surgery lessened the patient's symptoms of pain, numbness, and tingling.

ALLEGATIONS

The patient filed a lawsuit against Neurosurgeon A alleging a wrong-level surgery of the spine. Instead of performing surgery at C5-6 and C6-7, the neurosurgeon performed the anterior discectomy and fusions at C6-7 and C7-T1.

LEGAL IMPLICATIONS

The consultant physicians who reviewed this case agreed that Neurosurgeon A performed surgery at the unintended C6-7 and C7-T1 levels, instead of the C5-6 and C6-7 levels. One orthopedic surgeon stated that wrong level spinal surgery falls into the category of a "never event," and should not happen if proper safety measures are employed.

This consultant also stated that the safest and most common method for identifying the correct level in this type of surgery is via intraoperative x-ray or fluoroscopy that allows the surgeon to make a "marking shot." None of the intraoperative imaging performed during the May 2016 surgery reflects that a marking shot was established, nor does Neurosurgeon A describe doing so in his operative report.

Another consultant criticized Neurosurgeon A for not obtaining post-fusion diagnostic imaging to confirm that the fixating hardware was located at the correct levels.

DISPOSITION

This case was settled on behalf of Neurosurgeon A.

RISK MANAGEMENT CONSIDERATIONS

In a 2008 survey of members of the American Academy of Neurological Surgeons, 50 percent of responding surgeons reported that they had performed "one or more" wrong-level surgeries during their career. Not only can a surgeon potentially operate on the wrong side of the spine or the wrong level, but specific challenges exist related to spinal localization. In the survey, examples of wrong-site surgeries included surgical intervention at the incorrect location, performing the wrong procedure, or operating on the wrong patient.[1]

However, wrong-site surgery can occur in all surgical specialties. Thankfully, effective strategies from organizations such as the Joint Commission and the National Association of Spine Specialists (NASS) have proven to help minimize the risk of wrong-site surgery.

In these guidelines, both organizations stress the importance of strong communication between the surgical team and the patient as an essential preventative measure. This includes all participants in a surgery — surgical team and, when possible, the patient — be involved in marking the site of surgery. Involving the patient helps to ensure that everyone understands the surgery to be performed and allows the surgical team to confirm that the intended surgery matches the patient's symptoms and diagnosis.

The Joint Commission's Universal Protocol consists of a comprehensive checklist for all surgical team members to follow before and during a procedure. The checklist consists of the following three major sections:[2]

1. **Conduct a pre-procedure verification process** to "verify the correct procedure, for the correct patient, at the correct site." Items in this section include verifying the availability of relevant documentation (such as executed consent forms, pre-anesthesia assessment, and patient history); labeled and

properly displayed diagnostic and radiology test results (such as imaging or biopsy reports); and any required blood products or special equipment.

2. **Mark the procedure site** before performing the procedure. Guidelines specify that "[a]t a minimum, mark the site when there is more than one possible location for the procedure and when the procedure in a different location could harm the patient." Ensure the mark is unambiguous and sufficiently permanent to be visible after skin preparation and draping; at or near the procedure site; and used consistently throughout the organization. For spinal procedures, the protocol recommends marking the general spinal region on the skin and using intraoperative imaging techniques to locate and mark the exact vertebral level.

3. **Perform a time-out** after all questions or concerns are resolved during the pre-procedure verification process. Conduct the time-out immediately before starting the procedure or making an incision. The time-out process should be standardized; started by a designated member of the surgical team; and involve all relevant, immediate members of the surgical team. All members should actively communicate during the time-out. During the time-out, team members must agree, at a minimum, on the following:
    a. correct patient identity;
    b. correct site; and
    c. procedure to be done.

    If the same patient has two or more procedures being performed by different specialists or surgeons, another time-out must be conducted before starting each procedure. Completion of the time-out should be documented in the patient record.[2]

See source 2 below to access more detail on the Universal Protocol.

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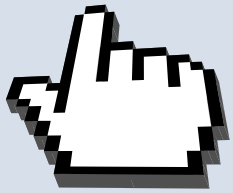

UNNECESSARY SURGERY AND PATIENT DEATH

by Laura Hale Brockway, ELS, Vice President, Marketing

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

A 46-year-old man came to the emergency department (ED) on August 9 reporting left flank pain. The patient had a history of kidney stones. Imaging revealed he had a 4 mm stone in the left ureter. The patient was transferred to another hospital and placed under the care of Urologist A.

PHYSICIAN ACTION

On August 11, Urologist A took the patient to surgery and attempted to remove the stone via ureteroscopy. The procedure was unsuccessful because Urologist A could not safely reach the stone. He placed a ureteral stent to dilate the ureter for a second attempt at stone extraction. Urologist A documented that he planned to discharge the patient and that he would remove the stent in the office one week later.

The patient continued to report pain and remained in the hospital. On August 17, Urologist A took the patient back to surgery for a second attempt at stone extraction. He could not reach the stone, but he did remove the stent.

Following the surgery, Urologist A and the patient discussed a plan to wait and see if the patient could pass the stone without further intervention. The patient was discharged on August 18.

The patient went to the ED on September 9 with bilateral flank pain. The emergency medicine physician documented that the patient passed a kidney stone while in the ED. The patient did not tell the ED physician of his previous treatment with Urologist A.

On September 13, a scheduler from Urologist A's practice called the patient to schedule surgery to remove the stent. The patient understood that the stent had already been removed on August 17 while he was in the hospital. As a result of this phone call, the patient sent a text message to his wife stating, "I guess I'm going to have to sue the urologist." A later text message from the patient indicated that he had been called again to schedule surgery to remove the stent, "they swear it's still there."

The patient came to the hospital on September 21 for surgical removal of the stent. During the induction of anesthesia, the patient's heart stopped. He could not be resuscitated and died. An autopsy revealed a 95 percent occlusion of the left anterior descending artery. The cause of death was a sudden myocardial infarction from pre-existing severe atherosclerotic and cardiovascular disease.

ALLEGATIONS

A lawsuit was filed alleging that Urologist A failed to meet the standard of care in taking the patient back to surgery for stent removal when the procedure was not indicated or necessary. The plaintiffs also alleged that staff at Urologist A's practice should have known the planned stent removal had already been performed while the patient was in the hospital.

LEGAL IMPLICATIONS

The plaintiff's expert made credible arguments that Urologist A should have inquired about whether the patient had already passed the kidney stone and should have been aware that he had already performed the planned procedure on the patient. The plaintiffs also criticized office staff for scheduling a procedure that had already been done. Urologist A's operative report from the procedure to remove the stent — which occurred on August 17 — was not timely scanned into the patient's office chart.

The defense argued that the patient shared responsibility for the outcome because he did not tell Urologist A during pre-op that there was a question of whether the stent remained and that the stone had passed during an ED visit two weeks earlier. Did the patient know he was about to undergo an unnecessary procedure? If so, why did he proceed?

Regarding causation, the defense asserted that the patient's reaction to the induction of anesthesia could not have been predicted or anticipated. The results of the patient's preoperative work-up were normal, and the patient had undergone a cardiac work-up six months earlier. The results of that cardiac work-up were also normal. The patient had twice recently undergone anesthesia without issue.

DISPOSITION

This case was settled on behalf of Urologist A and his practice.

RISK MANAGEMENT CONSIDERATIONS

Delay in documentation and incomplete records were issues that greatly affected the defense of this claim for Urologist A. The operative report that confirmed the removal of the stent had not been timely added to the patient's record. This led office staff to schedule the patient for a procedure that had already been done.

Ideally, operative reports, hospital discharge summaries, consultant reports, and other outside documentation should be added to patients' office records contemporaneously. Doing so means the information needed for diagnosis and treatment is available to all members of the health care team.

Additionally, office staff should be trained on what actions to take if there is a discrepancy between what a patient reports and what is documented in the patient's record. Are these conversations documented in the medical

record? Does appropriate follow up occur if a patient's operative history is unclear? Does follow up include alerting the treating physician? Does staff understand the critical nature of this type of discrepancy?

The defense of this case was also compromised by lapses in communication between the patient and his providers. The patient was not forthcoming about his medical history and the procedures performed by Urologist A when he went to the ED on September 9. He was equally uncommunicative with Urologist A, as the patient did not report that he had passed the stone in the ED or that he believed the stent had already been removed. If this had been reported to Urologist A, he could have confirmed the stent removal by reviewing the patient's hospital records.

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