Catastrophic Complication

Medical Leader	•
Medical Expert	
Communicator	
Advocate	•
Scholar	
Professional	
Collaborator	
Manager	•

2014 (November) - DAY 1 – Supplementary Question

You are the Director of Medical Services at a 300 bed regional hospital.

One morning, one of the non-clinical executives of the hospital asks whether you have heard that a patient had developed an incomplete quadriplegia after a spinal operation two weeks before. The executive had heard this as a 'cafeteria rumour'. While you are sceptical, you check the operating theatre lists for the rumoured operation and find that, indeed, a patient was transferred to the spinal unit of a large metropolitan hospital two days after a cervical laminectomy.

You obtain data that shows that, on average, there are 1 – 2 cervical spine surgeries are performed each month at your hospital by two visiting orthopaedic surgeons who also have a busy (but unquantified) practice in the large local private hospital.

You phone your Director of Surgery to find out why this catastrophic complication had not been formally reported as a clinical incident. He advises you that in his opinion, this is a well-described but uncommon complication of cervical spine surgery and further states that 'if we had to report every clinical complication in the hospital incident-reporting system, the surgeons would never have time for clinical work'. He further states that the case would be discussed at the Surgical Mortality and Morbidity Committee in six weeks' time, as the agenda for the next M and M is already full.

You quickly review the clinical record and find that the patient had been admitted 13 days prior to surgery with symptoms of cervical myelopathy and that surgery was delayed until a post-operative bed was available in the Intensive Care Unit. You also note with dismay that the clinical notes are very sparse and, in particular, that there is no documentation of progressive neurological examinations (apart from the admission examination) for the entire pre-operative period.

Questions

1. **What are the risk management and clinical governance implications of this scenario?**
2. **What are your immediate and longer term actions?**

Guidance for Censors:

Risk Management and Clinical Governance

- Patient safety – data on complication rates in cervical spine surgery within institution compared with national or benchmarking data
- Was any form of Open Disclosure performed with the patient and family?
- Culture of reporting within clinical groups - when is a clinical complication an incident?
- Clinical documentation standards
- Anticipate potential medicolegal action
- Safety of service and role of hospital – are the numbers of operations being done at your facility enough to maintain expertise amongst clinical support staff (assuming that the surgeons are doing sufficient cases in private – good candidates may comment on the need to gain this data which may be available through central health authority).
- Clinical documentation standards
- Role and training provided to Director of Surgery in risk management

Immediate Actions

- Find out current status of patient.
- Ascertain whether open disclosure has occurred.
- Expedite either internal M & M review +/- independent external review of management of case.
- Given low numbers, consider moratorium on cervical spine procedures until reviews completed. Meet with surgeons and Director of Surgery to explore options.
- Have surgeons notified medical indemnity organisation?
- Notify hospital insurers

Longer Term Actions

- Role of hospital to provide cervical spine surgery
- Improve documentation and early notification of significant clinical events
- Flexibility of M & M functioning within the hospital