COMMUNICATION ISSUE LEADS TO RETAINED FOREIGN BODY

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DESCRIPTION

Following successful cranial surgery, a 54-year-old man experienced back and lower extremity pain which was ultimately diagnosed as being related to an intrathecal lumbar catheter left behind at the time of surgery eight months earlier.

KEY LESSONS

- Consider options that limit over-reliance on memory.
- Implementing structured communication tools (i.e., SBAR, I-PASS) may help to mitigate risk and improve outcomes.
- Patients play an important role in their own care and recovery.
- Retained foreign body cases are difficult to defend.

CLINICAL SEQUENCE

After completing successful brain surgery on a 54-year-old patient, the attending asked the resident to remove the intrathecal catheter. As the resident started to remove the catheter, a piece broke off and attempts to remove the piece were not successful. The resident notified the attending, who decided to leave the catheter in place, with the intention of removing it at a later date. In the operative note, the resident noted that a portion of the catheter broke off and was retained in the lumbar spine. The patient was not informed of the retained catheter before his discharge.

When the patient returned to his surgeon for follow-up care, he complained of postoperative back pain.

Several months later, the patient complained to his primary care physician of continuing back pain so bothersome he could not drive or work. A CT Scan showed a retained tip of the spinal drain catheter from the surgery. This finding was conveyed to the surgeon, who informed the patient and his family and apologized, explaining that he had simply forgotten about the retained catheter. Following a minor procedure to remove the catheter, the patient's pain resolved.

ALLEGATION

The patient brought a claim against the neurosurgeon for failure to inform him of the retained catheter in his spine, and failure to respond to the significance of his postoperative back pain.

PATIENT SAFETY RESOURCES

DISPOSITION

The claim was settled in the low range (<$100,000).

ANALYSIS

Clinical Perspective

Since the patient had already been closed, the attending surgeon had left the operating room when the resident encountered trouble with the catheter. When he was notified, the attending asserted that it was more important to end the operation and "go in at a later point and remove it." Unfortunately, this plan was forgotten.

Even a successful surgery leaves some tasks to be done-some with potentially serious health implications for the patient. Highly reliable care is not built on memory or working in isolation. A minute or two spent on a quick "debriefing" of all surgical team members can help identify, for everyone, what is left to do, when it will be done, and who will do it. Team training would emphasize the need to establish a shared mental model to ensure everyone sees the big picture.

The patient made a follow-up visit to the surgeon's office, representing another opportunity to remember the retained catheter. He complained of post-operative back pain.

Listen, engage, and include patients in their care and recovery. In light of an unexpected post-op complaint, a quick review of the operative report would have revealed the source and the diagnosis. Additionally, had this patient been told soon after surgery or upon discharge of the need to remove the retained catheter piece, he certainly would have brought it up during the follow-up visit.

Patient Perspective

I understand that what happened with the catheter was secondary to a complicated procedure that saved my life, but it's not like nobody knew there was something still in me. How could they simply forget to tell me or to schedule time to remove it?

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ANALYSIS

Patients expect a process of checks and double-checks that keeps them from being harmed in the course of medical treatment. They want to trust the system and its ability to catch and correct errors. Unfortunately, all the good rapport a clinician has established with a patient can be undone by a relatively small misstep.

As a result of the pain (from the retained catheter), my life was on hold. I couldn't drive or go back to work for almost a year. And it''s not like I didn't tell them about it. When I heard about the retained catheter, I was shocked that they hadn't put two and two together.

Following a physical complaint to a definitive diagnosis is an important consideration. Patients who believe their doctors are concerned enough about them to make sure a problem is resolved are more likely to trust the physician in other areas of their care.

To his credit, once he figured out what happened, my surgeon admitted the retained catheter had slipped his mind and he apologized for the error.

Being available and forthcoming with patients (and families) is expected under all circumstances, and essential when things are not going well.

Risk Management Perspective

Many opportunities arise for information to be lost, inaccessible, or forgotten as care is handed off across multiple settings and providers.

Integrating a hand-off tool into the EHR may help reduce preventable adverse events.

The attending in this case was not liable for the resident breaking the catheter and failing to remove it successfully, but he was deemed responsible for failing to adequately follow-up that complication after having signed the operative note.

A careful reading of the operative notes before signing off on them provides a critical review of needed follow-up for the attending. Juries are not usually sympathetic if told the attending did not read a note that he or she signed.

Legal Defense Perspective

Retained foreign body cases are difficult to defend. The attending took full responsibility for the complication and apologized to the patient. The claim was quickly settled, taking into account the pain and discomfort and disability (lost wages) related to the retained catheter.

Restraining from finger-pointing is critical in mounting the best defense for any malpractice claim. An open, honest, and timely apology may reduce the likelihood of a lawsuit, or improve the chances of a successful settlement for a reasonable sum.