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Risks Associated with the Morbidly Obese Patient

by Jack F. Menendez, MD, FACS, CWS



Morbid obesity is defined as being 100 pounds overweight or as having a body mass index (BMI) above 35. BMI is derived by dividing the weight in kilograms by the height expressed in meters squared ($BMI=Kg/M^2$). Over the past 22 years, the prevalence of obesity in America has risen from 12.2 to 28.6 percent of the population. The percentage of the obese that are morbidly obese has likewise risen from 3.2 to 8.1 percent. There are now approximately 10 million people with a BMI of 35 - 40 and another six million people with a BMI over 40.

Co-morbidities Associated with Morbid Obesity

The co-morbidities of morbid obesity affect essentially every organ system:

Cardiovascular - Hypertension and Coronary Artery Disease

Respiratory - Sleep Apnea and Chronic Asthma

Gastrointestinal - Gallstones and Cirrhosis of the Liver

Metabolic - Type 2 Diabetes Mellitus and Dyslipidemia

Endocrine/Reproductive - An increased incidence of carcinoma of the breast and carcinoma of the ovary

Neurological - Pseudotumor Cerebri

Morbid obesity is a life-enveloping and life-shortening affliction. If all of the co-morbidities of morbid obesity are taken together, morbid obesity is second only to cigarette smoking as the underlying cause of death in the United States.

By definition, the morbidly obese patient is sick when first encountered. They have ongoing serious cardiac and hemodynamic problems as well as serious respiratory difficulty such as Sleep Apnea Syndrome (SAS) and Obesity

Hypoventilation Syndrome (OHS). The symptoms of SAS include loud snoring, nocturnal awakening and daytime somnolence. SAS has been implicated in automobile accidents when it was determined that the patient had fallen asleep while driving. Patients with OHS become hypoxic and hypercarbic on room air. These patients frequently have cor pulmonale and are polycythemic.

It is also difficult to examine the morbidly obese radiologically, because the x-ray equipment found in most hospitals is not capable of producing useful studies of these patients. Plain films are frequently under penetrated, and sonograms and CT scans are not clear.

Morbidly obese patients presenting for surgery are difficult to intubate and are at great risk of postoperative acute airway obstruction and respiratory arrest. On examination, these patients have fatty infiltration of the tongue and fat deposits on the uvula and pharynx.

Surgical incision in the morbidly obese has a high incidence of dehiscence and wound infection. Internal bleeding is more difficult to diagnose. Morbidly obese patients also have obstetrical problems. Forty-eight percent of morbidly obese laboring parturients require emergency cesarean section versus nine percent of normal-size patients. It should be noted that 62 percent of morbidly obese women have cesarean sections overall versus 24 percent of normal-size patients.

In short, the morbidly obese patient is sicker than the non-obese patient. Every system of the body is affected either mechanically, biochemically or both. Therefore, they have to be treated with greater care because there is much less margin for error. The problems associated with morbid obesity affect both the quality and length of life of these patients.

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Risk Management Issues

When the morbidly obese patient presents for any type of medical treatment, it is important to evaluate the patient for the current complaint and for all of the co-morbidities that may be associated with the patient's obesity.

- A complete physical examination, including biochemical and metabolic studies, diet and nutritional history, psychological assessment, and fitness assessment should be considered before any medical or surgical intervention is carried out.
- The patient's medical risks of obesity are heightened by the presence of concurrent illnesses, such as poorly controlled diabetes or high blood pressure, and coexisting dysfunctions of the organs or limbs due to morbid obesity. Also, lifestyle habits such as smoking or physical inactivity should be assessed.
- A physician should be especially astute when making a differential diagnosis in a patient who presents with various symptoms that are co-morbid conditions of morbid obesity.
- Because morbid obesity is so prevalent, these patients are commonly seen in clinical practices and are at increased risk for the development of several conditions that require surgical intervention. These include cholelithiasis, GEERD, osteoarthritis and certain malignancies including breast, endometrial, colon and prostate cancer. The possibility of impaired immune function and a poor outcome with infection following any type of surgical intervention is increased.

- Anesthesia poses an increased risk in the morbidly obese patient. The preoperative visit, by both the anesthesiologist and the surgeon, should include both verbal and written communication as to the planned procedure. The associated risks that the morbidly obese patient may face in the operating room and postoperatively (a common postoperative complication in the morbidly obese is respiratory arrest after extubation) should be outlined well on the consent form, and the patient should have a clear understanding of the risk for any procedure in order to make an informed decision regarding surgical operability.●

This is an update of MAG Mutual's 1999 article "Potential Risks Associated with Morbidly Obese Patients" by Dr. Jack F. Menendez.

References:

1. Buchwald H. Overview of bariatric surgery. *Journal of the American College of Surgeons*. 2002;3:367-375.
2. Damia G. Perioperative changes in functional residual capacity in morbidly obese patients. *Br. J. Anaesth*. 1988;60:574-578.
3. Klain J. Liver histology abnormalities in the morbidly obese. *Hepatology*. 1989;10 (no.5):873-876.
4. Prasad U. Influence of obesity on the early and long-term results of surgery for coronary artery disease. *Eur J Cardio-thorac Surg*. 1991;5:67-73.

Closed Claim Abstract - Complications of Morbid Obesity

By Karol DeVito, R.N., Risk Management Consultant

CASE ONE:

A 39-year-old male patient presented for surgical treatment of morbid obesity. The patient was six feet tall and weighed 420 pounds, placing him at twice his ideal body weight. His medical history included hypertension, pneumonia, knee surgeries, kidney stones, sleep apnea and prior treatment with Redux.

The surgeon noted the Roux-en-Y gastric bypass to be "uncomplicated, but technically difficult." Post-operatively, the patient was transported to the recovery room intubated. One hour later, he was noted to be able to lift his head and arms and was shaking his head "yes" to having the endotracheal tube removed. He was

extubated and noted to be awake and talking when he developed respiratory distress and subsequent cardiac arrest. ACLS was immediately initiated and the patient was re-intubated. He was later transferred to the ICU where he remained comatose until his death five days later. The patient's wife filed a lawsuit against the surgeon and the hospital alleging failure to administer proper post-operative care which resulted in pulmonary arrest and death.

CASE TWO:

A 40-year-old male underwent surgical revision of a laminectomy at L4-L5 to remove and replace spinal cages for repair of a failed spinal

fusion. A general surgeon was responsible for the initial access to the anterior spine, while an orthopedic surgeon performed the spinal surgery. The patient's medical history included morbid obesity (340 lbs.), sleep apnea, nervous system problems, glaucoma, prior anterior and posterior spinal fusions and a motorcycle accident. During the initial part of the procedure, it was determined that a clot had developed in the patient's iliac artery. A vascular surgeon was contacted for assistance, but was delayed by a procedure he was currently involved in at another hospital. Eventually, revascularization was attempted, but was ultimately unsuccessful and the patient underwent an above-the-knee

amputation. The patient spent several months in the hospital for an assortment of complications including: adult respiratory distress syndrome (ARDS), renal failure, sepsis, recurrent wound infections and stump revisions. The patient brought suit against all of the physicians involved (general surgeon, orthopedic surgeon and vascular surgeon) alleging failure to have adequate coverage by a vascular surgeon and failure to adequately heparinize, as well as prolonged pain and suffering. Because of the many issues involved in this case, it was settled prior to trial.

Note: Each of these cases illustrates the increased risks associated with the morbidly obese patient. In case one,

despite proper extubation protocol, the patient respiratorily arrested, a post-operative risk in the morbidly obese. However, the care rendered was defensible due to the surgeon's thorough pre-operative evaluation which included a complete H&P, psychiatric consult, ABG, a signed consent form, as well as documentation in the progress notes of the informed consent discussion with the patient regarding the risks associated with the procedure; and excellent care provided by the medical team in the recovery room. The surgeon was dismissed from the lawsuit.

In case two, unfortunately, the patient experienced multiple surgical risks associated with morbid obesity

including wound infection, dehiscence and respiratory complications. Morbidly obese patients not only have a higher mortality rate compared to their normal weight counterparts, they also have higher morbidity rates with longer hospitalizations. The associated risks that the morbidly obese patient may face in the operating room and postoperatively should be outlined well on the consent form, and the patient should have a clear understanding of the risk for any procedure in order to make an informed decision regarding surgical operability. Documentation of the informed consent discussion should be included in a progress note.

Bloodborne Pathogen Exposure in the Physician Practice Setting

by Susan Millar, R.N., Risk Management Consultant

Closed claims data from MAG Mutual Insurance Agency's Workers' Compensation files indicate that sharps injuries account for more than one-half of all of our Workers' Compensation claims and have occurred three times more frequently than the next greatest incident type. Sharps injuries potentially expose healthcare workers to a variety of bloodborne pathogenic agents. Financial and emotional costs of bloodborne pathogen exposure to you and your employees can be catastrophic.

Sharps injuries are preventable. The incidence of sharps injuries can be reduced by the use of safer medical devices such as needleless systems, sheathing devices and other improvements.

The Occupational Safety and Health Administration (OSHA) cites the Bloodborne Pathogen Standard as the one most frequently violated. OSHA's Occupational Exposure to Bloodborne Pathogens Standard (29 CFR 1910.1030), published in 1991, was established to promote safety in the workplace and to help prevent workplace bloodborne pathogen exposure.¹ The entire directive, current recommendations and current forms may be downloaded from the OSHA Web site at http://www.osha-slc.gov/OshDoc/Directive_data/CPL_22_69.html.²

The Needlestick Safety and Prevention Act and Standards (passed by Congress November 6, 2001) requires healthcare providers to develop and implement

a written Exposure Control Plan. The Centers for Disease Control and Prevention (CDC) provides detailed instructions to help office practices comply. These can be found on the CDC's Web site www.cdc.gov.³ The National Institute for Occupational Safety and Health (NIOSH) publishes check lists and guidelines on the NIOSH Web page <http://www.cdc.gov/niosh/homepage.html>. Additionally, you may obtain a sample Exposure Control Plan from OSHA.⁴

The contemporary medical office practice must take strong measures to ensure the safety and well-being of its physicians and staff. With the strong guidance and support that OSHA, the CDC and NIOSH have given, it is clear that all healthcare providers can and must implement cost-effective and practical measures to promote sharps safety in the workplace and reduce these exposures. ●

References

1. CDC <http://www.cdc.gov/niosh/homepage.html>
2. Revision to OSHA's Bloodborne Pathogens Standard Technical Background and Summary <http://www.osha-slc.gov/needlesticks/needlefact.html>
3. Updated Compliance Directive for Bloodborne Pathogen Exposure, <http://www.osha-slc.gov/media/oshnews/nov01/trade-20011128.html>
4. Preventing Needlestick Injuries in the Healthcare Setting, DHHS Publication 2000-108, November, 1999, <http://www.cdc.gov/niosh/homepage.html>

For information regarding Workers' Compensation coverage, please contact Chip Goen at 800-282-4882 or 404-842-5584.

Disclosing Unanticipated Outcomes Under JCAHO Standard

By David Tansill, JD

Hospitals must establish procedures requiring disclosure of unanticipated outcomes in medical treatments and procedures if they seek accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A standard adopted by JCAHO effective July 1, 2001 provides that "patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes."¹ Whenever the actual outcome of a treatment or procedure differs significantly from the anticipated outcome, JCAHO expects the licensed practitioner or his or her designee to clearly explain the outcome to the patient and, when appropriate, the family.²

Hospitals across the country have adopted procedures to implement this new JCAHO standard. In turn, physicians have grown concerned that they may be placed in situations where they might jeopardize their ability to defend a potential medical professional liability claim if they comply with these procedures. Of course, the JCAHO standard does not require the admission of fault or liability. Physicians can comply with their hospital procedures by disclosing certain relevant facts and still not admit fault. Studies have shown that patient-physician communication problems are among the leading factors in a patient's decision to assert a professional liability claim.³ Effective communication, including appropriate disclosure of unanticipated outcomes can enhance a physician's relationship with the patient and perhaps eliminate one of the reasons the patient might consider suing the physician. Below, we highlight some concepts physicians may use in disclosing unanticipated outcomes to patients.

MAG Mutual Insurance Company encourages physicians to disclose poor outcomes, complications and adverse events as a standard risk management practice.⁴ Maintaining contact with a patient before and after an unanticipated outcome occurs has been MAG Mutual's recommendation for many years. The following communication guidelines may be useful when a physician confronts an unanticipated outcome.

1. Provide the patient or family a simple explanation of the known facts
2. Explain the known cause of the problem as accurately as possible without speculation
3. Do not use words which might imply negligence (e.g., error, wrong, mistake, accident)
4. Do not make disparaging comments about persons, products or organizations or engage in "fingerpointing"
5. Do not belittle any complication⁵

Obviously, the JCAHO standard does not require the physician to admit liability. There may be many causes of an unanticipated outcome, so assessment soon after an occurrence can often be speculative. Speculation does not help the patient understand the outcome and could wrongly imply medical negligence. Some commentators suggest physicians should apologize for medical errors. A better approach might be for the physician to express empathy or compassion for the patient's situation, while not apologizing for his or her actions. Saying "I'm sorry for your loss (or pain)" is an effective way to convey the physician's feeling of compassion, but saying "I'm sorry that I did not..." can imply or admit wrongdoing.

Compliance with procedures implementing the JCAHO standards on disclosure of unanticipated patient outcomes and the defense of medical professional liability cases are not mutually exclusive goals. With forethought, a physician can disclose factual information to a patient regarding an unanticipated outcome, and do so in a manner in which liability or fault is neither admitted nor implied. Physicians should consult with their medical professional liability insurers if they have questions concerning the disclosure of unanticipated medical or surgical outcomes.●

1. JCAHO Standard RI.1.2.2.
2. JCAHO Standard RI.1.2.2, Statement of Intent.
3. Alston & Bird, LLP, Healthcare Advisory, June 2001, "JCAHO New Patient Safety Standard: Disclosure of Unanticipated Outcomes" citing W. Levinson, "Physician-Patient Communication: A Key to Malpractice Prevention," 272 JAMA 1619 (1994).
4. MAG Mutual Insurance Company, Georgia Risk Management Handbook for the Medical Office Practice - No. 1-2000, Section II.3.1.
5. MAG Mutual Insurance Company, Section II.3.2.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment.

This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion.

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