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Patient complaints following bariatric surgery 2012–18

SHORT REPORT

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BACKGROUND

We examined complaints submitted to the Norwegian System of Patient Injury Compensation (NPE) following bariatric surgery, including the background for the complaint, the proportion of patients whose complaints were upheld, and the characteristics of complaints that were upheld.

MATERIAL AND METHOD

All complaints relating to bariatric surgery performed in the period 2012–18 were reviewed and categorised according to symptoms, findings and events relevant to the outcome of the complaint. Anonymous summaries from the experts' statements were reviewed and categorised according to year of decision, gender, age, basis for compensation or rejection, and whether the intervention was carried out in the public or private health service.

RESULTS

Forty-four (26 %) of a total of 171 applications for patient injury compensation were upheld. These applications represented 25 patients who had surgery in the public health service (19 % upheld) and 19 patients who were operated on in the private health service (51 % upheld). The single most common reason for a complaint being upheld (n = 18) was lack of indication for bariatric surgery.

INTERPRETATION

More post-bariatric surgery complaints were upheld for lack of indication than for surgical errors. Proper patient selection, good preoperative preparation, good information and shared decision-making are important factors for achieving the best possible bariatric surgery outcome. An interdisciplinary team that monitors patients over time can help ensure the quality of the entire treatment chain.

Main findings

Most complainants sought compensation for foreseeable problems and complications.

The single most common reason for a complaint being upheld was lack of indication for the procedure, mainly in the private health service.

Even complaints regarding relatively serious problems and complications were not upheld if the medical treatment was considered to have been performed correctly.

Surgical errors were relatively rare.

Bariatric surgery is a common procedure at Norwegian hospitals nowadays, with just under 3000 such operations performed annually; almost 2000 in the public health service and 1000 in the private health service (1). Following surgery, most patients experience substantial weight reduction and an improvement in obesity-related comorbidities (2, 3), and the incidence of perioperative complications is low (4). However, the risk of negative long-term side effects and complications is relatively high (3).

Patients who believe they have suffered an injury after treatment in the health service can apply for compensation through the Norwegian System of Patient Injury Compensation (NPE). There must be a failure in the medical treatment in order for a complaint to be upheld.

The purpose of this report was to map and identify common and significant injuries after bariatric surgery for which compensation was sought. Based on these results, we will discuss measures that can reduce the extent of such injuries.

Material and method

We analysed anonymous NPE data from all finalised complaints concerning bariatric surgery in the period 1 January 2012 to 31 December 2018. The lead author was given access to anonymised data from the NPE database, and is permitted to store the data in accordance with the Norwegian Archives Act (5) and in line with the consent granted in connection with claims for

compensation. Upon application, the NPE can provide data for the purpose of quality analyses. The database is anonymised, pursuant to Section 2 of the Norwegian Health Register Act, i.e. the data cannot be traced back to any individual, and use of the database does not require exemption from the duty of confidentiality.

All summaries of the experts' statements in the various complaints were reviewed and categorised according to the year of the decision, the complainant's gender and age, the grounds for upholding or rejecting a claim for compensation, and whether the treatment was carried out in the public or the private health service. The complaints were also categorised based on symptoms and pre-, peri- and postoperative events. The categorisation is not reproduced numerically, partly because the description of symptoms and findings was not exhaustive, and partly for privacy reasons despite the anonymisation of data, due to the potential recognition of a patient or treatment provider when there are few cases within a category. For the latter reason, several categories of upheld complaints were merged, see Table 1.

Table 1

Complaints upheld by the Norwegian System of Patient Injury Compensation (NPE) following bariatric surgery 2012–18

Category of upheld complaint in NPE	Reason given in the decision to uphold complaint	Number (total)	Public health service	Private health service
810	No indication for surgery	18	3	15
811	Should have been operated on (reoperated on) sooner	4	4	0
812	Incorrect treatment technique or method	7	7	0
816/817/818/819/844/828/845/ Exemption provision	Miscellaneous reasons[1]	15	11	4
Total	All	44	25	19

[1]Inadequate or absence of follow-up after treatment / Inadequate support, monitoring, supervision / Inadequate, absence of or incorrect medication / Incomplete or absence of examination or treatment / Inadequate investigation, findings not followed up / Communication failure or insufficient information / Incorrectly performed examination or test / Other factors, not further explained

Results

During the study period (2012–18), approximately twice as many patients underwent surgery in the public health service (n ≈ 14 000) as in the private health service (n ≈ 7000) (Jorun Sandvik, Norwegian Association for Bariatric Surgery, personal communication). A total of 171 people (72 % women) with a mean age of 40 years applied for patient injury compensation following bariatric surgery. Of these, 134 had surgery in the public health service, and 37 had surgery in the private health service. A total of 44 (26 %) complaints were upheld, of which 25 related to cases in the public health service (19 % upheld), while 19 were in the private health service (51 % upheld). Four of the complaints concerned perioperative mortality, with two deaths in each of the latter categories.

Most claims for compensation were based on one or more of the following symptoms and problems: chronic pain, nutritional problems, diarrhoea, nausea, asthenia, unwanted weight change and hypoglycaemia. There was a degree of overlap in several of the listed symptoms and problems.

The most common single independent reason for the NPE upholding a complaint (n = 18) was that the bariatric procedure was performed on erroneous grounds (category 810: No indication for surgery); 3 of these were in the public health service and 15 were in the private health service (Table 1). In the decision to uphold a complaint, it was assumed that the patient a) had not sufficiently tried more conservative treatment before surgery, b) was not suitable for this type of surgery due to poor mental (n = 6) or physical health, c) was not adequately informed about the procedure and the extent of it, d) did not receive adequate follow-up, and/or e) did not meet the body mass index (BMI) criterion for the procedure according to good medical practice (n = 10). None of the patients had cited any of these factors as a basis for complaint in their application.

Other upheld complaints are attributed to surgical errors such as anastomotic leakage, rotation of the anastomosis, tears and perforations in the intestine or adjacent organs. These were the most common reasons for a complaint being upheld in the public health service.

Other reasons that provided a basis for compensation were premature discharge from hospital, use of analgesics that masked symptoms, lack of follow-up of test results and lack of understanding of the severity of symptoms and thus delayed recognition of surgical complications.

Several of the summaries did not include exact information about the surgical method, and were not therefore subject to analysis.

Discussion

A small proportion of patients, less than 1 % of those who underwent bariatric surgery, applied for compensation. The available data indicate that a relatively larger proportion of patients who underwent surgery in the public health service applied for compensation, while the proportion whose complaints were upheld was higher in the private health service. The reason for this discrepancy is unknown. One possible explanation for relatively fewer privately operated patients applying for compensation may be that the NPE did not cover private health services until 2009. It may not be widely known yet that the NPE has been expanded.

The claims for compensation were mostly submitted on the basis of symptoms or problems that are well-known side effects of bariatric surgery, possibly accompanied by known but rare surgical complications. A failure in the treatment or the follow-up of the patient had to be shown, however, for a complaint to be upheld.

The most common reason for a complaint being upheld was 'no indication for the procedure' (41 % of the upheld cases), which was mostly seen in the private health service. According to national guidelines, assessment of surgical indication is a specialist task (6). Suitable candidates are those with a BMI ≥ 40 kg/m^2 or 35–39.9 kg/m^2 with concomitant weight-related comorbidities. The patient must first have tried to lose weight for at least six months using other methods under the guidance of a healthcare professional or bona fide commercial actor. Severe mental illness and substance abuse are relative contraindications, while preoperative lifestyle changes are considered necessary for a good result. For some patients, there seems to be too much of a leap from the desire to lose weight to bariatric surgery, and some service providers boast of short or no waiting times (7).

The therapist has a heavy responsibility to ensure that inclusion and exclusion criteria are thoroughly assessed and documented. The patient must be informed of both the advantages and disadvantages of elective bariatric surgery, so that they, together with the doctor, can choose the most suitable treatment method (3, 4).

The public specialist health service has an obligation to train surgeons and anaesthetists. It is therefore conceivable that these procedures are performed in hospitals by public health personnel with less surgical experience than their colleagues in the private sector and that surgical errors consequently occur more readily. All such procedures should be headed up and supervised by experienced specialists. Furthermore, having an adequate number of procedures is a known prerequisite for a good surgical pathway. It is not clear whether this is equally well safeguarded in all public hospitals.

Short and fragmented treatment pathways can increase the risk of incorrect patient selection (category 810) and lack of recognition of postoperative complications (categories 811 and 812). Treatment in interdisciplinary teams

that collaborate on patient education, preliminary examinations and postoperative follow-up over time is likely to help reduce the risk of such errors occurring.

The article has been peer reviewed.

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