

Gastroenterology

Claims Data Snapshot

2023



Introduction

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

This publication begins with insight into frequency and financial severity profiles by specialty. Then follows an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Gastroenterology is identified as the primary responsible service.

Keep in mind...

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Specialty benchmarking

Specialties have different frequency and financial severity profiles which combine to produce differing risk levels.

Severity Tier	High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology
	Low	Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology	Ophthalmology, Plastic Surgery, Pulmonology	Hospitalists
		Low	Medium	High
Frequency Tier				

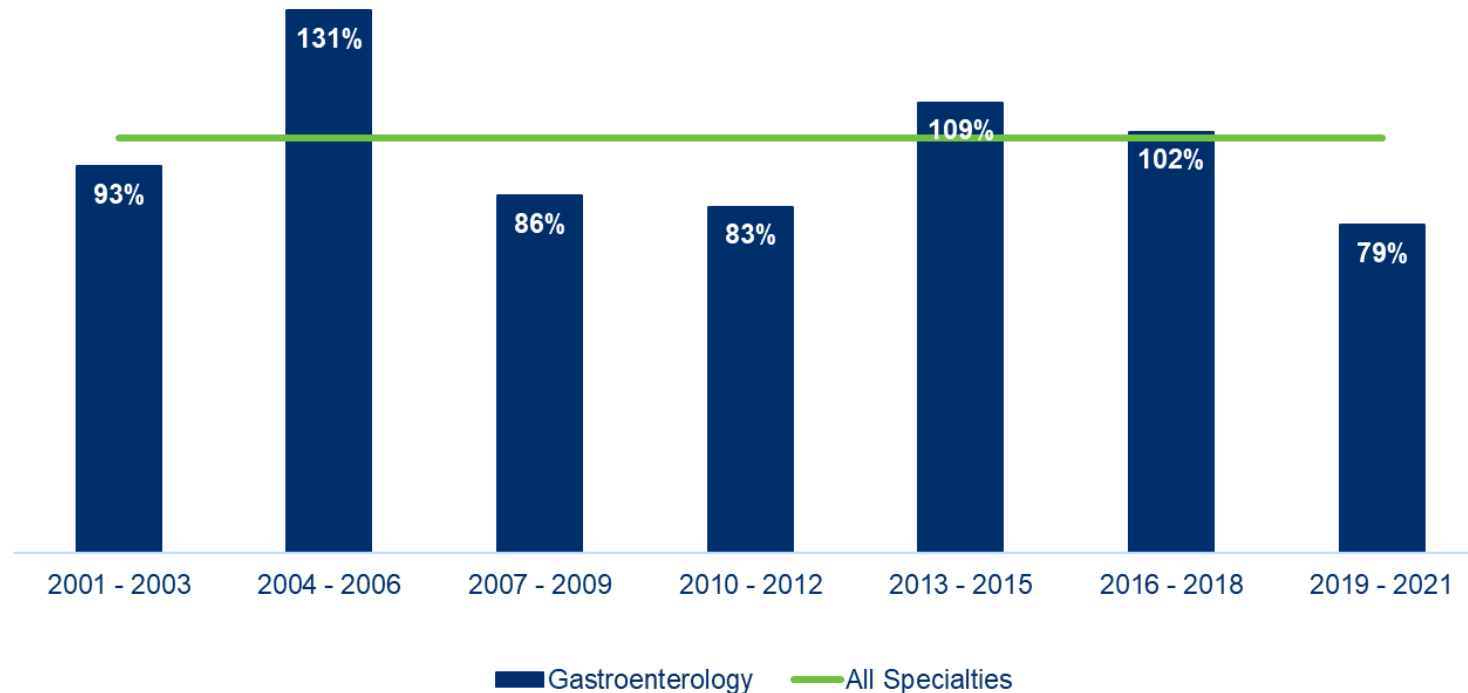
Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

Specialty trends – Gastroenterology

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Gastroenterology has an average financial severity per case and an average claim frequency compared to all specialties.

Average Severity - Gastroenterology Relative to All Specialties



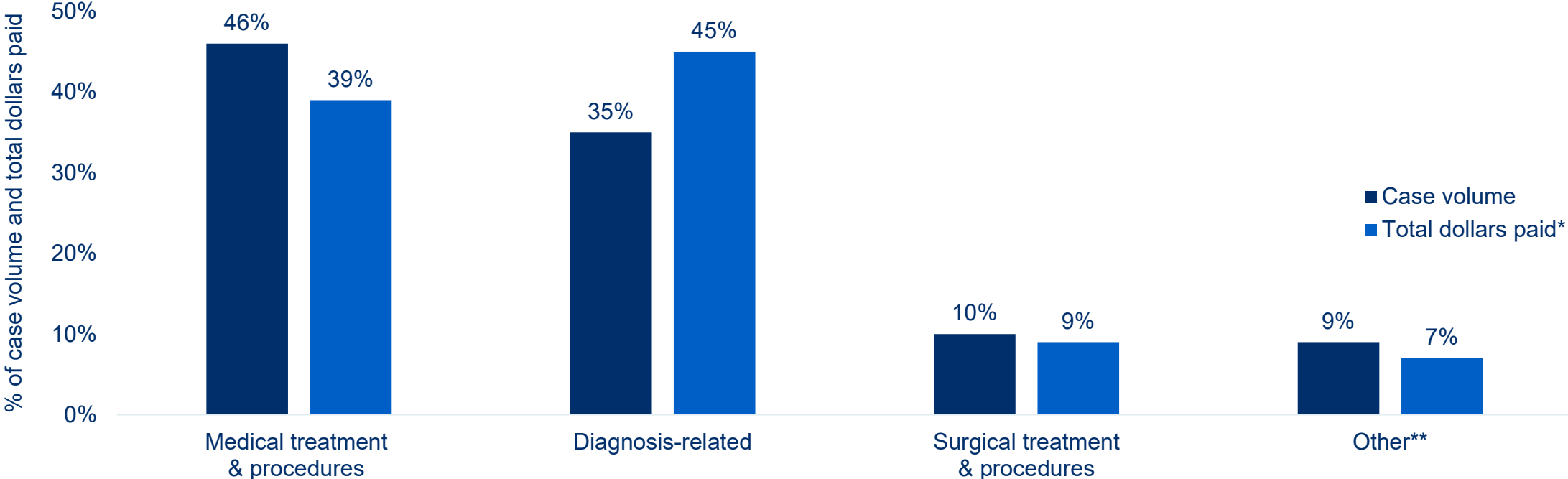
Key Points - Clinically Coded Data

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- **Medical treatment allegations account for 46% of Gastroenterology case volume**, and most commonly reflect cases related to improper procedural performance. Colonoscopies, ERCPs and upper endoscopies are the top three procedures noted. **Procedural performance cases can be impacted by delayed recognition of complications**, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.
- **Diagnosis-related allegations** account for more than one-third (35%) of Gastroenterology case volume. As would be expected, missed/delayed diagnoses of colorectal cancers are most prevalent amongst these cases. **These cases commonly reflect breaks in the diagnostic process of care**, most often in the initial diagnostic phase, including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, and delays or failures in ordering diagnostic testing. Failures during the patient follow-up process are also indicated, including delays in obtaining referrals/consults.
- **Surgical cases, again most commonly reflective of procedural performance cases, account for 10% of Gastroenterology case volume.** Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Clinical judgment factors, specifically a narrow diagnostic focus, suboptimal communication among members of the patient's care team, and management of known complications are key drivers of both clinical and financial Gastroenterology case severity.

Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.



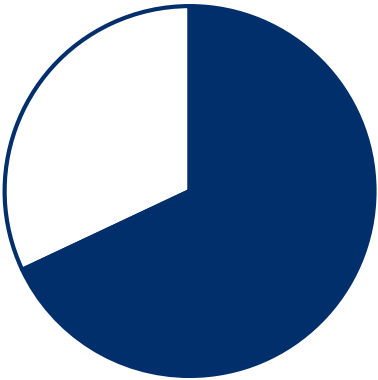
MedPro Group + MLMIC cases opened 2012-2021, Gastroenterology as responsible service (N=421); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

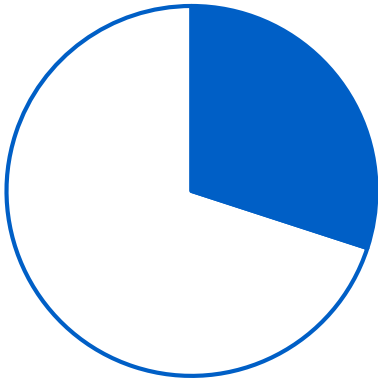
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Clinical Severity Categories	Sub-categories	% of case volume	<p>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</p>
LOW	Emotional Injury Only	3%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	36%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	61%	
	Major Permanent Injury		
	Grave Injury		
	Death		

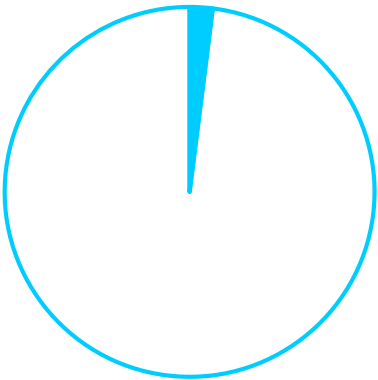
Claimant Type & Location



Ambulatory
68%



Inpatient
30%



Emergency
2%

Top Locations	% of case volume
Endoscopy/special procedures	39%
Office/clinic	27%
Patient room/ICU	16%
Ambulatory surgery	9%
Inpatient surgery/recovery	6%

Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

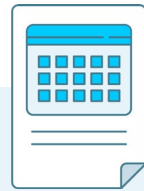
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



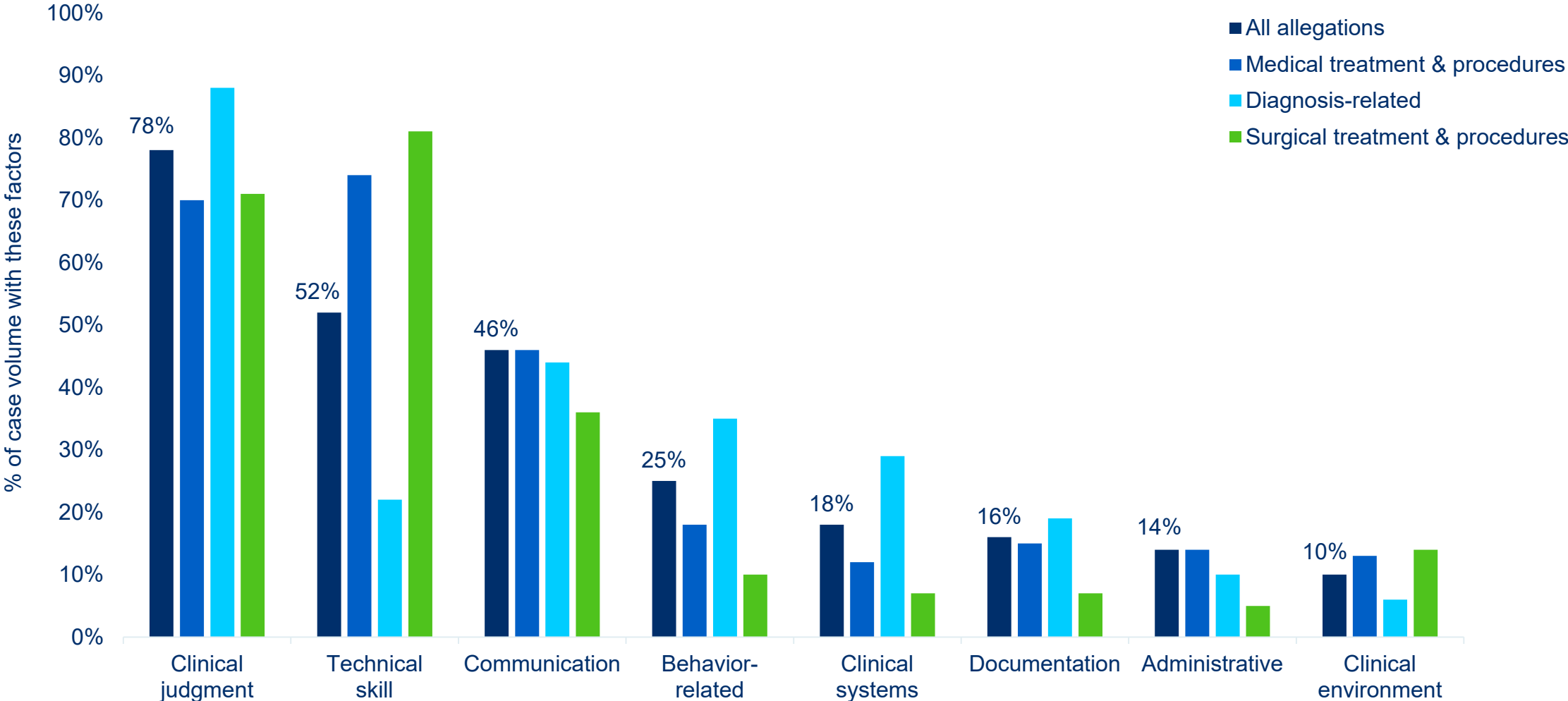
Technical skill

Contributing Factor Category Definitions

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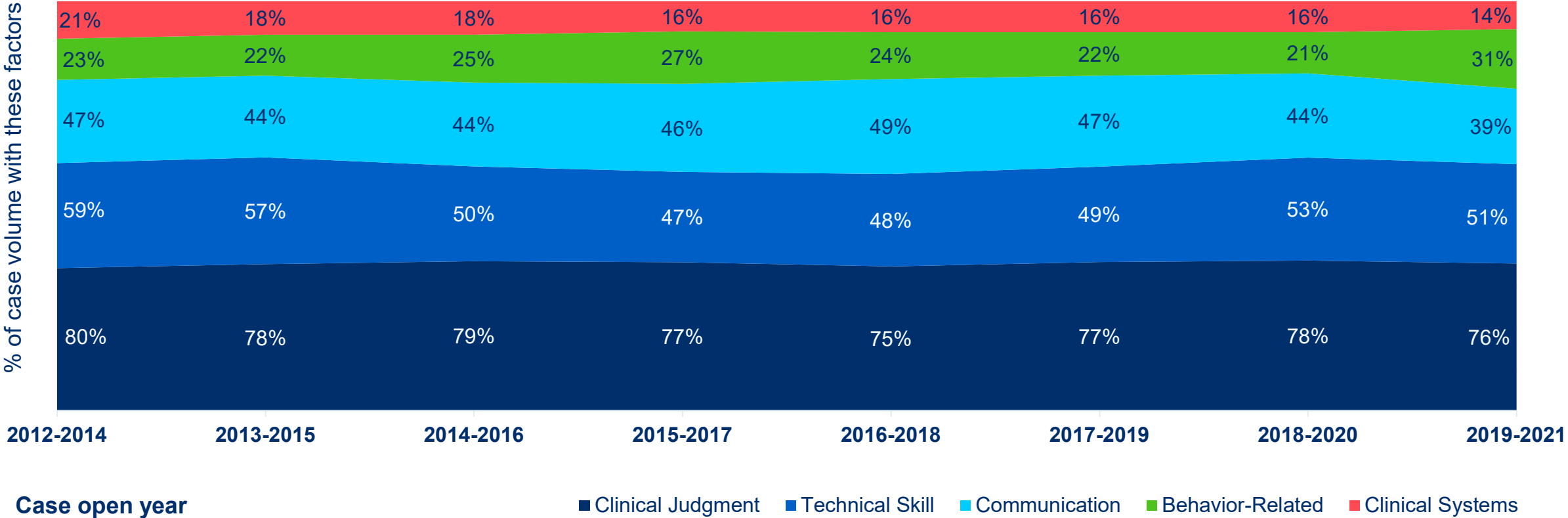
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2012-2021, Gastroenterology as responsible service (N=421); More than one factor per case, therefore totals >100%

Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

MedPro Group + MLMIC cases opened 2012-2021, Gastroenterology as responsible service (N=421); More than one factor per case, therefore totals >100%

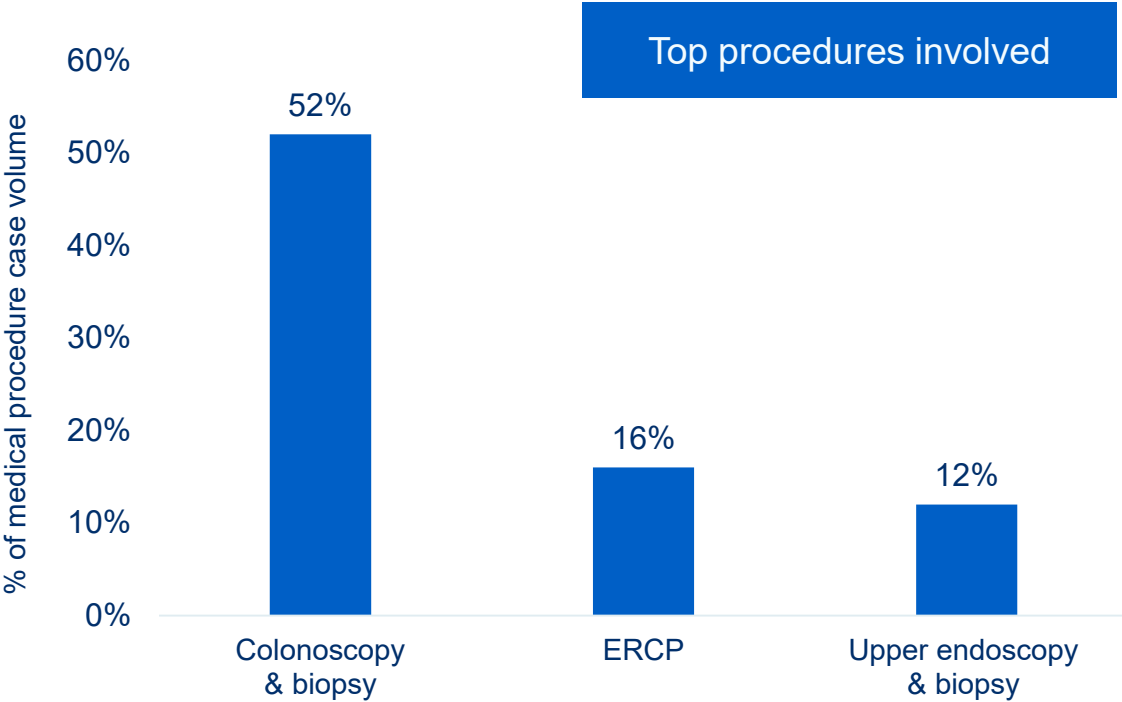
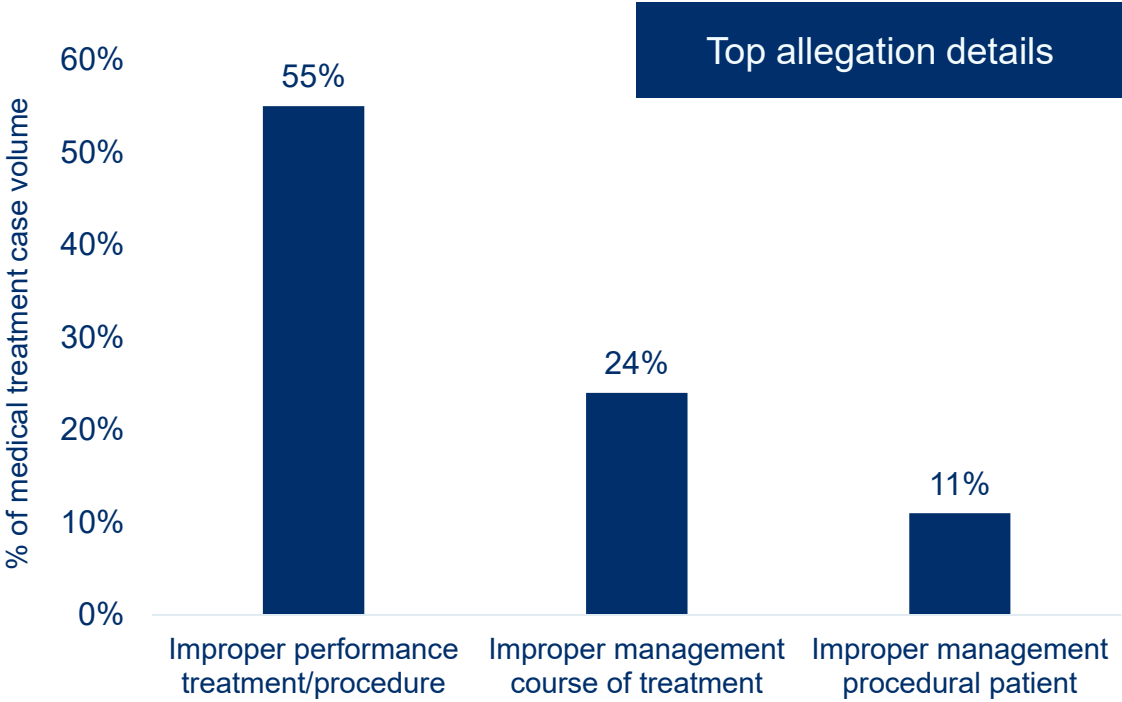
Focus on Most Common Drivers of Clinical and Financial Severity

Factors associated with high clinical severity outcomes	(CJ) failure to appreciate/reconcile signs/symptoms/test results (40%)	% of high severity case volume
	(CJ) selection/management of most appropriate procedure (31%)	
	(TS) occurrence/management of known complications (29%)	
	(CJ) failure/delay in ordering diagnostic test (25%)	
	(CO) suboptimal communication between providers about patient condition (24%)	
Factors associated with the costliest indemnity payments	(CJ) narrow diagnostic focus – failure to establish differential diagnosis (49%)	% more expensive than the average indemnity payment*
	(CO) suboptimal communication between providers about patient condition (42%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (29%)	

Clinical judgment factors, specifically a narrow diagnostic focus, suboptimal communication among members of the patient’s care team, and management of known complications are key drivers of both clinical and financial Gastroenterology case severity.

AD: administrative; BR: behavior-related; CE: clinical environment; CJ: clinical judgment; CO: communication; CS: clinical systems; DO: documentation; SU: supervision; TS: technical skill
 MedPro Group + MLMIC cases opened 2012-2021, Gastroenterology as responsible service (N=421); More than one factor per case, therefore totals >100%; *limited to factors associated with >= 15 cases

Focus on Medical Allegations



Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

Focus on Diagnosis-Related Allegations

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Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses* noted in these cases.

Cancers
60%

Primarily colorectal, pancreatic, liver and stomach

Lower gastrointestinal disorders
12%

Includes intestinal obstruction, appendicitis, peritonitis

Focus on Diagnosis-Related Allegations

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Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

Phase 1

Initial diagnostic assessment 82% of cases	Patient notes problem & seeks care
	History & physical
	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

Phase 2

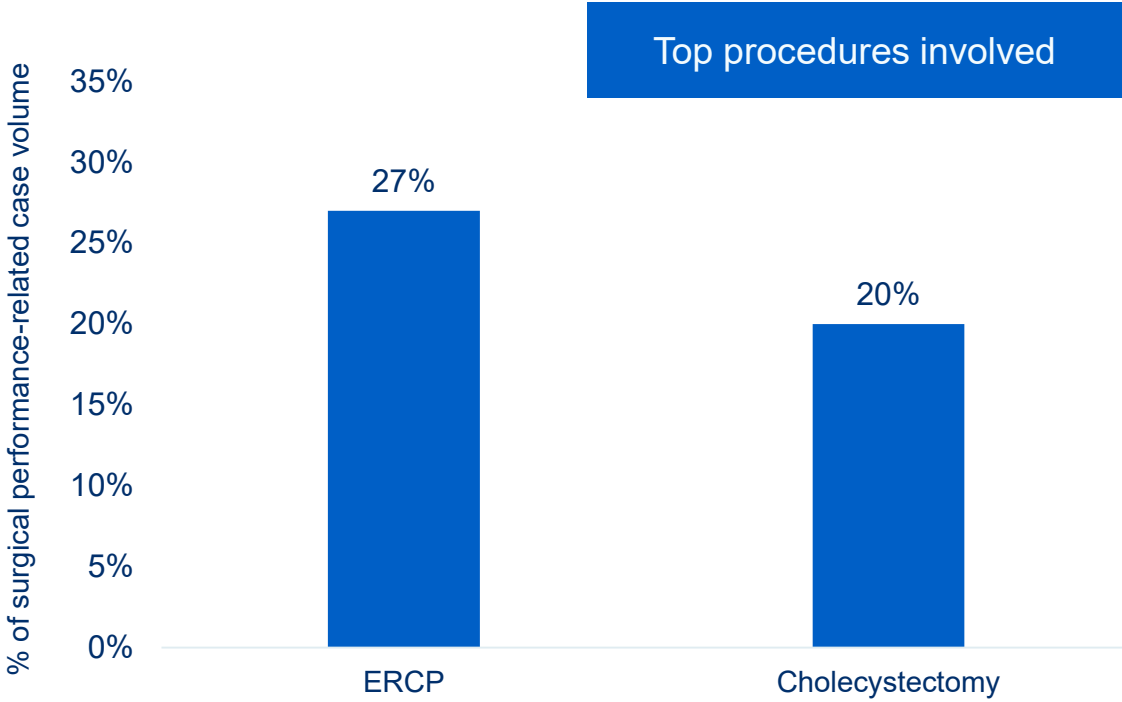
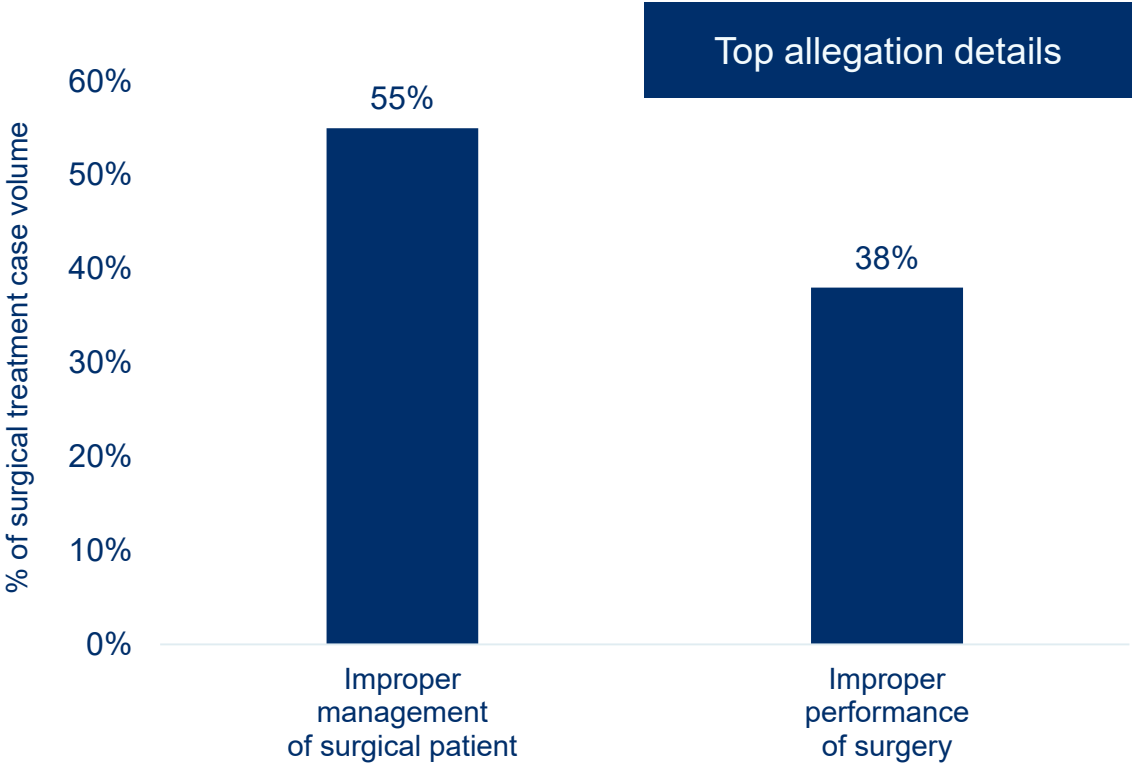
Testing and results processing 27% of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

Phase 3

Follow-up and coordination 56% of cases	Physician follows-up with patient
	Referrals/Consults
	Patient information communicated among care team
	Patient compliance with follow-up plan

MedPro Group + MLMIC cases opened 2012-2021, Gastroenterology as responsible service (N=421); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

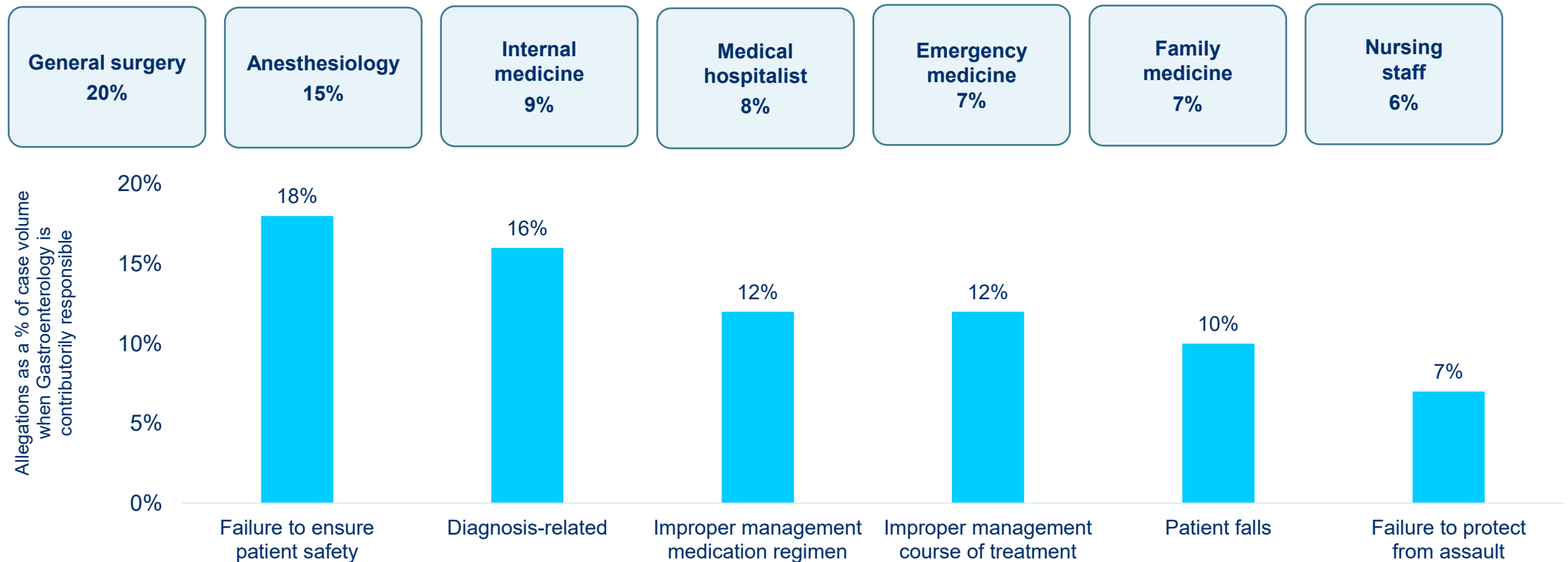
Focus on Surgical Treatment Allegations



Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.

Contributorily Responsible

Although this analysis is focused on cases reflecting Gastroenterology as the primarily responsible service, another 300 cases identify Gastroenterology as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.





The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Gastroenterologists.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

Case Examples

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SETTLED

\$1.8M

CONTRIBUTING FACTORS

Clinical judgment

Failure to appreciate and reconcile relevant sign/symptom/test result

Patient assessment – misinterpretation of diagnostic studies

Failure/delay in obtaining consult/referral

Clinical system

Failure/delay in reporting findings

Communication

Communication among providers – regarding patient's condition

Patient/family education – follow up instructions

DELAY IN DIAGNOSIS OF CANCER OF THE APPENDIX RESULTING IN METASTASIS AND DEATH

On 8/12, a 43-year-old female presented to the Emergency Department with complaints of right-sided abdominal pain for the past four days. Abdominal CT **showed a dilated fluid-filled appendix**. The patient was admitted with a plan to complete a second CT in the morning and treated with antibiotics. On 8/13, the patient had a General Surgery (Gen Surg) consult, who opined that the patient may need an exploratory laparotomy. A Gastroenterology (Gastro) consult noted the follow-up CT was normal. Of note, **no written Radiology report was available** for the repeat CT, and per the Gen Surg, **the second CT was abnormal**. Differential diagnosis included gastritis, Crohn's disease and appendiceal mass. **Both Gastro and Gen Surg recommended surgical follow-up**. The patient's pain resolved, and she was discharged home.

On 8/26, the patient underwent a colonoscopy by Gastro, which if normal, meant that the patient would need to be seen by Gen Surg. Colonoscopy showed no signs of inflammatory bowel disease. **A copy of the report was sent to the patient's primary care provider and to Gen Surg; however, there was no additional documentation indicating the need for follow-up sent to either the Gen Surg or to the patient**. Gastro later stated that he verbally advised the patient of the need for follow-up with Gen Surg, but patient's husband denies this and **patient never followed-up**. A note placed in the chart on the last date of contact with Gastro stated "Patient advised to schedule appointment with Gen Surg as per GI (Gastro) request. Patient stated she will call on her own to schedule; did not want to at this time. The patient was given Gen Surg's info and asked to advise office when this was scheduled."

Almost three years later, the patient was admitted to the hospital with severe abdominal pain. CT and ultrasound **showed multiple abdominal masses. An exploratory laparotomy with multiple biopsies showed metastatic mucinous adenocarcinoma/stage IV (primary site: appendix)**. The patient underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy, omentectomy, appendectomy, tumor debulking, and chemotherapy. However, she died seven months later.

Gen Surg had noted the need for surgical follow-up in the discharge summary from three years earlier, and had a copy of the patient's colonoscopy report, but no chart on patient. **No effort was made to contact the patient to ensure follow-up**.

Gastro was criticized for failure to advise patient that she possibly had an appendiceal mucocele-which is a pre-malignant lesion needing surgery, and for failure to follow-up with patient to make sure he saw the surgeon. **If the appendix was removed three years earlier, the patient's medical course may have been drastically different**.

Case Examples

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SETTLED

\$250,000

CONTRIBUTING FACTORS

Administrative

Access/scheduling/waiting issues – pt was sent to ED because Gastro had busy office schedule

Clinical environment

Weekend/holiday

Clinical judgment

Selection/management of most appropriate surgical procedure (ERCP vs non-invasive MRCP)

Technical skill

Occurrence of known complication

IMPROPER PERFORMANCE OF ERCP RESULTING IN NECROTIZING PANCREATITIS, SEPSIS AND DEATH

A female in her late 70s had been treating with a Gastroenterologist (Gastro) for many years for a variety of issues. She called for an appointment to address **recurrent complaints of abdominal pain, heartburn, constipation and reflux. However, due to the office's busy schedule, she was unable to schedule an appointment quickly.** Shortly thereafter, on a Saturday, the patient presented to the Emergency Department (ED) with complaints of right upper quadrant pain radiating into the mid-epigastric region. Diagnostic testing revealed elevated liver function and lipase results. She was discharged with instructions to follow-up with Gastro.

Within a week, she was able to obtain a CT ordered by Gastro, which showed non-dilated bile ducts; physical exam revealed mild jaundice. The patient had a history of prior cholecystectomy and abnormal lab work results, therefore Gastro **had concerns for possible common bile duct (CBD) stone and the plan was to perform an** endoscopic retrograde cholangiopancreatography (ERCP). Risks, benefits and alternatives were discussed.

An attempt at performing an ERCP was done, however, access to CBD could not be obtained and the procedure was terminated. The patient was observed in the post anesthesia care unit and was discharged in stable condition. Later that afternoon, **the patient developed abdominal pain and vomiting, and was instructed to return to the ED.** Upon arrival, her blood pressure was 188/77, then 217/90. An emergent CT of the abdomen was done at 10:30pm. At 1:30am, her blood pressure dropped to 74/52. Left femoral catheter was placed at 3:30am. At 3:37am, the patient developed agonal breathing and bradycardia. A code was called, but she was unable to be revived.

The autopsy noted the **cause of death to be sepsis and necrotizing pancreatitis due to complications occurring during performance of the ERCP.**

Risk Mitigation Strategies

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- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**
- **Conduct a thorough assessment of the patient pre-procedure.**
 - Ensure that all testing and specialty evaluations are available for review prior to induction; in an ambulatory setting, these details might not always be as readily available as in the inpatient setting.
 - Maintain a consistent post-procedure assessment process.
- **Communicate with each other.**
 - Actively collaborate with other members of the patient's procedural care team – including all operating/procedural and recovery room staff. Coordinate the steps of the patient's care, including post-operatively.
 - Talk also to the patient/family, elicit a comprehensive patient history and conduct a thorough informed consent with the patient.
- **Engage patients as active participants in their care.**
 - Consider the patient's health literacy and other comprehension barriers. Recognize that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.
 - Do not use a “no news is good news” and/or “If you don't hear from us, you can assume your results are normal” approach. Create and review problem lists at each visit. Ensure a process for relaying test results to both patients and providers.
 - Track missed appointments and follow-up attempts.
- **Document.**
 - The procedural record is critically important for detailing the pre-procedure patient assessment, intra-procedural steps, and post-procedural sequence of events. Discrepancies or gaps in the details/timing make it much more difficult to build a supportive framework for defense against potential malpractice cases.

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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