Allegations & Procedures

- Procedural issues account for almost half of the allegations (Figure 1).
- Diagnostic-related cases, including delays in diagnosing or failures to diagnose cancers and procedural complications, are, on average, more than twice as expensive to defend (Figure 1).
- More than three-fourths (87%) of all gastroenterology-related scope cases arose in an outpatient setting.
- More than half (54%) of cases resulted in a high clinical severity patient injury.
- The majority of all cases involve colonoscopies (Figure 2).

Figure 1. Top Allegation Categories*

*Total paid = dollars paid for expense & indemnity
Figure 2. Procedure Types (all cases)*

*by percent of claim volume

**Top Responsible Services**

Gastroenterologists are most frequently noted as responsible in these cases. Each case has one primary responsible service, and can have more than one contributing service. In this data set, nursing staff was noted in another 10% of cases, bringing nursing-involved scope procedures to 16% of the total.

Figure 3. Top Primary Responsible Services (all cases)

- Gastroenterology: 58%
- General surgery: 14%
- Family/Internal Medicine: 10%
- Anesthesiology: 6%
- Nursing: 6%

**Patient Injuries: Focus on Procedural Performance Cases**

Bowel punctures/perforations were noted in 73% of the procedural-related cases (Figure 4), correlating with the patients who required surgical repair. Death, infections, prolonged hospitalizations and hemorrhages were also noted most often.
Data Insight: Liability Risks Associated With Endoscopies

**Figure 4. Top Patient Injuries: Procedural Cases**


**Risk Factors**

Risk factors are broad areas of concern that may have contributed to allegations, injuries or initiation of claims. Generally more than one factor is associated with a case. The top risk factors noted in all scope-related cases, as distributed among low, medium and high clinical severity injuries, are shown in Figure 5.

**Figure 5. Top Risk Factors (all cases)**

![Bar chart showing top risk factors. Clinical judgment: Low/Medium 51%, High 84%; Technical skill: Low/Medium 49%, High 83%; Communication: Low/Medium 51%, High 37%; Behavior-related: Low/Medium 14%, High 27%; Documentation: Low/Medium 25%, High 9%]

Clinical judgment issues are more prevalent in the high severity cases, and interestingly, so are patient behavioral issues - specifically, noncompliance with treatment/follow up.
Each risk factor category is comprised of multiple sub-category details. Those specific to high severity allegations are noted in Figure 5a.

**Figure 5a. Top Risk Factor Details in High Severity Cases**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Details</th>
<th>% of claim volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>Occurrence of known complication</td>
<td>35%</td>
</tr>
<tr>
<td>Clinical judgment</td>
<td>Failure/delay ordering diagnostic test</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Selection of most appropriate procedure</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Failure to appreciate relevant symptom/test result</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>Failure/delay to obtain consult</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>Premature discharge</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Narrow diagnostic focus</td>
<td>12%</td>
</tr>
<tr>
<td>Behavior-related</td>
<td>Patient noncompliance</td>
<td>23%</td>
</tr>
<tr>
<td>Communication</td>
<td>Among providers</td>
<td>20%</td>
</tr>
<tr>
<td>Documentation</td>
<td>Insufficient/inconsistent/inaccurate</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Case Study #1**

A male patient in his mid-40’s presented to the Emergency Department with right flank pain. A CT revealed a bowel obstruction secondary to a colon mass, which was suspicious for malignancy. The patient was admitted; gastroenterology and general surgery consults were ordered. The surgeon evaluated the patient, and noted no bowel function. His documentation in the chart included “consider colonoscopy vs. surgery; can’t prep from above” (due to bowel obstruction). The gastroenterologist did not come to the hospital to evaluate the patient, but ordered an oral bowel prep (mag citrate) to be given, along with enemas if needed. The gastroenterologist was unaware of the surgeon’s evaluation of the patient. A colonoscopy was scheduled for the following day.
During the night, the nurse noted that the patient vomited 400ml of dark brown liquid, but did not contact the physician. The gastroenterologist saw the patient prior to the colonoscopy, but did not read the nursing notes in the chart. He did note the patient had developed abdominal distension, and that the “prep did not pass through.”

Upon initiation of the colonoscopy, an anesthesiologist was called to provide additional anesthesia support (administration of propofol), but decompression of the stomach had not been ordered. The patient vomited and aspirated during the colonoscopy; post-procedure, his status deteriorated and he died. Upon review, it was questionable if there was appropriate indication for the patient to have had a colonoscopy.

- **Risk issues:** selection of procedure; patient monitoring; communication among providers; insufficient documentation (vomiting & aspiration were not noted in the procedural record); occurrence of known complication

### Focus on Occurrence of Known Complications

When known scope-related procedural complications occur, most often there are associated clinical judgment issues, including inadequate patient assessments (i.e., failure to appreciate symptoms, premature discharge of the patient, delays in ordering diagnostic tests). In addition, the data reveals several of these cases (17%) also involved inadequate informed consent for procedures and difficulties in setting patient expectations for outcomes. A robust informed discussion that includes patient consent is key to mitigating the potential for a future medical malpractice claim. An inadequate informed consent process fails to adequately prepare the patient for possible outcomes and can help to stoke a patient’s dissatisfaction with care received.

### Case Study #2

A female patient with a history of Barrett’s esophagus and a positive occult blood test underwent a colonoscopy. The signed informed consent document noted risks of bleeding and perforation of the colon. The nurse gave the consent form to the patient to sign; the gastroenterologist was running late and did not have a verbal informed consent discussion with the patient prior to the procedure.
The patient tolerated the procedure well under conscious sedation, but then vomited in the recovery area and complained of abdominal pain (nursing staff did not report the patient’s symptoms to the physician). Zofran was given, but nursing documentation noted the absence of vomiting and no pain. She was discharged to home.

Several hours later, the patient presented to the Emergency Department with nausea, vomiting and right shoulder pain. Diagnostic testing revealed a splenic hematoma with rupture. She underwent a splenectomy and endured a complicated recovery.

- **Risk issues:** inadequate patient assessment resulting in premature discharge; failure to appreciate symptom; communication among providers; inadequate consent; insufficient documentation of clinical findings; occurrence of known complication

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**Resources**

- Data Snapshot: Gastroenterology
- Who Is Responsible for Informed Consent?
- Checklist: Risk Management Considerations for Procedures (and Surgeries)

**Data Source:** MedPro Group closed claims data, 2008-2017

This document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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