When a patient is dissatisfied with his or her care, he or she can consult an attorney, who will consult a physician “expert” to determine if a doctor has deviated from the standard of care, and whether that deviation caused a negative outcome. In the cases where I found deviation from the standard of care leading to a negative outcome, the errors made by the gastroenterologist fell into five primary categories. These categories of error have taught me valuable lessons that have improved the way I practice gastroenterology. I hope that by highlighting these errors, I can improve how gastroenterologists care for their patients, thereby decreasing the number of claims against them.

**1)Failure to perform the basics- The 3 Cs.**

**Communicate:** Communicating empathy and concern towards an anxious patient is a skill that not all docs and staff do well, but the ability to communicate with patients is the best protection against lawsuits. ***A study in 1994 showed that OBGYN physicians who are sued most often had poor patient satisfaction scores, and poor communication was the most common complaint.*** I reviewed a case involving a patient with a remote history of an injured right shoulder, making movement of her right arm difficult. Prior to a routine colonoscopy, the patient communicated her history to the gastroenterologist, endoscopy staff and anesthesiologist. When the patient awakened from sedation in the recovery area, the patient reported that the right arm was awkwardly positioned behind the back, leading to immediate and long-term pain. While I did not find deviation from the standard of care, my impression from reading the complaint was that the doctors and nurses could have avoided a potential lawsuit by listening and empathizing, rather than downplaying and disregarding.

My practice’s doctors communicate with every patient in recovery after the procedure, and if a patient expresses a concern on the follow up call the next day, the doctor is expected to call the patient immediately.

**Chart Review :** One case where I found deviation from the standard of care involved a patient who bled significantly after endoscopic dilation, requiring a prolonged hospitalization. The gastroenterologist who performed the dilation saw the patient in the office before the procedure, documented a history of atrial fibrillation, but did not document the patient’s use of coumadin, which had been documented by the primary care doctor several months earlier. In addition, the same gastroenterologist wrote a note on the day of the procedure that also failed to document Coumadin use. When the patient presented to the ER after the endoscopic dilation with hematemesis, the INR was 3.5. In my written opinion, I stated that the gastroenterologist performing the procedure was responsible for reviewing the chart and asking the patient about the use of blood thinners, especially since the patient had a history of atrial fibrillation.

Gastroenterologists performing procedures should always ask about the use of blood thinners or any relevant information that would affect the safety of the procedure. Oftentimes, a simple chart review would help to reduce risk of complications like aspiration pneumonia, bleeding, and perforation. Several years ago, in response to a patient who showed up for a colonoscopy while still taking Coumadin, my practice created a pop-up alert in our EMR for all patients who take a blood thinner. Always review the chart.

**Consent:** Under the legal doctrine of informed consent, the doctor must provide enough information to help the patient make rational healthcare decisions. Many lawsuits involving endoscopic complications cite informed consent as an issue. ***In an American Society of Gastrointestinal Endoscopy survey from 2007, 21% of those surveyed had been sued, and in 42% of these instances informed consent was an issue.*** Plaintiffs may argue that the risks of a procedure were never explained to them as part of the informed consent, but doctors are not obligated to list or verbalize every potential complication as part of the informed consent process. For example, I reviewed a case of splenic laceration that was caused by a routine colonoscopy, but the failure to mention this rare complication prior to colonoscopy did not represent a deviation from the standard of care. Conversely, doctors may attempt to use the informed consent as blanket defense against the occurrence of a complication that is listed on the consent form. However, the Supreme courts of Virginia and Pennsylvania have ruled that doctors can not use informed consent to shield them from a complication that was included on the consent form.

When I obtain informed consent, I ensure that the patient is mentally competent to understand the risks, benefits and alternatives to the procedure that I plan to perform, and pay special attention to higher risk patients where endoscopic intervention may lead to serious injury and even death.

2) **Poorly trained staff:** Years ago, I performed a colonoscopy with biopsies on an elderly person with chronic progressive diarrhea. In the recovery area, I informed the patient and his spouse that they would receive biopsy results in about one week, and that the patient could take over the counter antidiarrheals as needed until then. While they waited for the biopsy results to return, the diarrhea persisted so they called our office several times while I was away on vacation. Each phone encounter was documented by my staff in our EMR, and the patient was instructed to go to the ER if the diarrhea worsened. Once the biopsies revealed microscopic colitis, another provider in my office prescribed Budesonide and the diarrhea eventually resolved. Three months after the colonoscopy, he was seen by an advanced practitioner in my practice who documented that the diarrhea had resolved.

When the board of medicine in my state informed me that the aforementioned patient and spouse had filed a complaint about my negligent care, I reviewed all the telephone calls, office visits, and recommendations in the EMR, and realized that my staff's excellent documentation in the EMR protected me from ever appearing before the state medical board. Thinking back on the complaint, I think the patient's spouse was probably upset about having to communicate with my office staff and not me, all the while watching a loved one's health deteriorate.

**3) Practicing on an island:** Whenever I encounter a complicated diagnostic or therapeutic case, I often resort to several online resources, including Up To Date, Pubmed, American College of Gastroenterology, and American Society of Gastrointestinal Endoscopy. Equally helpful is texting with my colleagues about the case, and seeing their immediate feedback. By

using reliable information and opinion, I ensure that I practice the standard of care supported by the available medical literature and other gastroenterologists in my geographic area. I have reviewed cases where a gastroenterologist or non-gastroenterologist could have avoided error through consultation with another physician. One case involved a misplaced gastrostomy tube. After having a gastrostomy feeding tube replaced by a gastroenterologist, a patient came to the emergency room complaining of abdominal pain with feeding. The ER doctor injected dye into the G tube to confirm placement, and told the patient's mother that the tube was in proper position and ready to use for feeding. Unfortunately, the patient developed peritonitis after resuming G tube feeds, and died from sepsis. The radiologist who reviewed the G tube study the next morning reported that dye was actually extravasating into the peritoneum. In my written opinion, I stated that the emergency physician should have consulted with a radiologist before telling the patient that the G tube was properly placed.

Another demonstration of practicing on an island involves a case I reviewed involving a poorly prepped colonoscopy in a patient with a history of precancerous polyps. The gastroenterologist who performed the colonoscopy documented a poor prep from the rectum to the cecal cap, and told the patient to return for a repeat colonoscopy in two years. Consulting with colleagues or reviewing the literature may have alerted the physician that a repeat colonoscopy should have occurred much sooner, probably within three months. Unfortunately, the patient presented four months later with a perforation due to a large cecal cancer.

**4) Failing to recognize when patients are sick.** Not all patients are the same. Most outpatients in a gastroenterology practice are not sick. But problems can arise in higher risk patients like those with Crohn's disease and ulcerative colitis due to the natural history of these diseases and the potential toxicity of the medications. Identifying patients in your practice who are at higher risk for complications will alert you and your staff to give them more attention when they call to tell you that they aren't feeling well.

I reviewed the unfortunate case of an adolescent who had several months of worsening abdominal pain and significant weight loss, requiring two hospitalizations over the course of one month. During the second hospitalization, she was found to have ileocolitis on a colonoscopy consistent with Crohn's disease, but despite an office visit and several phone calls documenting her intractable pain, she only received antidiarrheals, antispasmodics, and mesalamine. She eventually developed perforation leading to peritonitis, ileocolonic resection and ileostomy. In my written opinion, I opined that the gastroenterologist's failure to recognize the severity of the patient's symptoms resulted in injury, and that if the patient had received appropriate medications like prednisone and Remicade, peritonitis and surgery could have been prevented.

To enhance patient communication and satisfaction, my practice has a policy requiring all physicians, NPs, and PAs to respond to all phone call encounters within 24 hours. To prevent complications and hospitalization of our patients with Crohn's disease and ulcerative colitis, my practice designated an employee to track medications, bloodwork, and vaccinations for these higher risk patients.

Inpatients are almost always sicker than outpatients, and the risk of medical error in the hospital is high due to myriad factors including medication errors, errors related to anesthesia, hospital acquired infections, missed or delayed diagnosis, avoidable delay in treatment,

inadequate follow-up after treatment, inadequate monitoring after a procedure, failure to act on test results, failure to take proper precautions, and technical medical errors. A 2016 study from Johns Hopkins suggests that medical errors are now the third-leading cause of death in the U.S., having surpassed strokes, Alzheimer's, and diabetes. In addition, one in seven Medicare patients receiving care in a hospital are victims of a medical error.

One inpatient case that stands out in my memory is a middle aged patient who presented to the ER in the afternoon with severe unexplained abdominal pain. An abdominal and pelvic CT scan was unremarkable. The ER physician called a gastroenterologist to perform a consultation. Over the next 24 hours, the patient's condition deteriorated, with worsening abdominal pain, hypotension, increasing white count, and lactic acidosis. The gastroenterologist failed to interview and examine a very sick patient until 24 hours after admission. After seeing the patient, the gastroenterologist recommended transferring the patient to a tertiary care center without ordering a repeat CT scan or surgical consult. When the patient arrived at the tertiary hospital later that day, the patient was already septic, and an exploratory laparotomy revealed mesenteric ischemia. I opined that the gastroenterologist's failure to recognize the severity of the patient's condition contributed to the patient's death.

5) **Poor documentation**. If you have practiced gastroenterology long enough and routinely perform procedures, you have probably encountered complications like bleeding from polypectomy; perforation due to endoscopic dilation or sphincterotomy; and pancreatitis due to ERCP. Moreover, you may have been sued for one of these unfortunate complications. ***More than one in three physicians, 34 percent, have had a medical liability lawsuit filed against them at some point in their careers,*** says one of three trend reports published by the AMA's Division of Economic and Health Policy Research. The longer that a physician has practiced, the more likely it is that they experience a lawsuit.

I have reviewed cases of injuries related to colonoscopy, including splenic laceration, colonic perforation, and missed cancer, but as long as the gastroenterologist obtained informed consent, performed proper documentation, and promptly addressed the complication, I could not find deviation from the standard of care. In the cases where I discovered a deviation from the standard of care, poor documentation is the most common case. In one case I reviewed, the gastroenterologist failed to photograph and document proper visualization of the cecum, resulting in a missed cecal cancer. In another case, an inmate with abdominal pain was evaluated by the prison nursing staff, who never documented performing an abdominal exam. The patient's abdominal pain persisted, eventually leading to peritonitis from perforated diverticulitis, and the patient died.

Since my practice started using electronic medical records in 2010, the process of proper documentation has become more organized and uniform. Every office visit, procedure report, telephone encounter, diagnostic test, and patient complaint or complication is documented legibly and organized into easily accessible compartments, and then stored in the cloud for future review. The robust documentation capability of an electronic medical record has definitely protected me and my partners from frivolous lawsuits by allowing us to prove that everything we did fell within the standard of care.

I can confidently state that I am a better gastroenterologist now than when I started my clinical practice in 2001. While first-hand experience has taught me most of what I know, my review of medical errors in the field of gastroenterology has taught me the importance of communication, chart review and informed consent; creating a practice with well-trained staff; reviewing the literature and consulting with other gastroenterologists when faced with complex, higher risk patients; recognizing when patients are sick and deserve more attention; and the need to properly document my actions with regards to patient care.