

# Risk management opportunities for Gastroenterology

## 1. Communication



Gastroenterologists can reduce malpractice risk through effective communication with patients. **1.** Pre-procedure counseling should include the nature, goals and risks of the proposed treatment or procedure, including risks of refusing the proposed treatment or procedure. **2.** Elicit and respond to patient concerns. **3.** Make recommendations, confirm patient's agreement, or continue the discussion. **4.** Thoroughly document informed consent.

## 2. Reusable endoscopes



A recent [study](#) determined the contamination rate of reprocessed GI endoscopes to be 19.98 percent. For reusable endoscopes, familiarize yourself with the updated [Multisociety guideline](#) on reprocessing flexible GI endoscopes and accessories and the additional [infection control resources](#) available through ASGE.

## 3. Perforation risk



Inadvertent punctures and perforations account for over 30% of the injuries involved in GI malpractice cases. Screen patients for risk factors for esophageal or bowel perforation, and develop plans for managing perforations identified during or after endoscopy procedures. Patients at higher risk for perforation include

those over the age of 75, and patients with comorbidities such as diabetes mellitus, chronic pulmonary disease, congestive heart failure, cerebrovascular disease, renal insufficiency, and liver disease.

## 4. Anesthesia risk



Evaluate patients for risk of an anesthesia-related adverse event and assign an ASA score. Minimize risks during periprocedural sedation according to available guidelines such as those from the [American Society of Anesthesiologists](#) (ASA) and the [American Society of Gastrointestinal Endoscopy](#) (ASGE).

## 5. Post-procedure discharge



Photograph anatomic landmarks encountered to demonstrate quality benchmarks. Communicate to the patient all procedural findings, interventions, and complications if any occurred. Use the “teach back” method to help confirm patient understanding of all discharge instructions.

## 6. Comprehensive follow-up systems



Track results and communicate procedural findings to co-treaters and the patient. Document reminders to patients about follow-up tests and appointments. Contact patients about “no-shows” and reiterate the potential risks of failing to obtain recommended treatment.

## Gastroenterology Case Study



The patient, a 60-year-old male, presented to a GI clinic for EGD and colonoscopy for evaluation of bloody stools and anemia. The EGD revealed a hiatal hernia, and colonoscopy was significant for a vascular malformation in the cecum which was cauterized. Additional findings included internal hemorrhoids and diverticulosis in the sigmoid colon. No complications were noted during either procedure.

Post-procedure, the patient complained of abdominal pain and cramping, and he became diaphoretic and hypotensive. The nursing staff contacted the gastroenterologist, who ordered IV fluids and an EKG. An hour later, the patient's pain level had increased from 5/10 to 10/10 and he was examined by the gastroenterologist, who noted a soft abdomen with positive bowel sounds and some gaseous distention. He advised the patient of the possibility of bowel perforation and recommended an abdominal x-ray at the local ER, as imaging was not available at the clinic. The patient declined and opted to remain at the clinic for further monitoring. Approximately 3 hours later, the patient voided urine and reported significant improvement in his pain, and his vital signs remained stable. The patient was subsequently discharged home on Cipro and Flagyl. The following morning, the patient's wife called to report continued abdominal pain, and she was advised to take the patient to the ER. The patient was subsequently admitted to the hospital and diagnosed with a suspected bowel perforation with secondary septic shock and acute renal failure. The patient underwent a laparoscopic surgical bowel resection with ileocolic anastomosis and hernia repair; intraoperative findings revealed 700cc of murky fluid in the posterior cecum, micro perforations, and stool stains. The patient was hospitalized on ten subsequent occasions for treatment of a chronic infection, and he underwent placement of an ileostomy due to breakdown of the surgical anastomosis. The patient was out of work for 11 months during his recovery. One year later a malpractice lawsuit was filed. Defense experts noted several issues including inadequate assessment, no abdominal imaging done, no post-op temperature recordings and a lack of documentation of the patient's refusal of care. **The lawsuit was settled for \$239K.**



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