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How to Mitigate the Risk of Medical Malpractice Claims

Dr. Buch:
As clinicians, providing the best quality of care is paramount, but in procedure-intensive specialties, medical malpractice is a notable concern. So what do we need to know about common malpractice claims in gastroenterology?

Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch. And joining me today to help us understand this important topic is Dr. Michael Weinstein. Dr. Weinstein is the President and CEO of Capital Digestive Care, one of the largest single-specialty GI practices in the United States, and he's also currently serving on the AGA Board of Trustees as a clinical counselor.

Dr. Weinstein, welcome to program.

Dr. Weinstein:
Thank you, Peter. I appreciate you having me on.

Dr. Buch:
To start us off, Dr. Weinstein, what are the most common malpractice claims in gastroenterology?

Dr. Weinstein:
As you mentioned, being a procedural specialty, one tends to think that most of the malpractice claims that we might have are related to the procedures that we perform because they either will turn out great or occasionally have an untoward event, so procedures are certainly a large component of the reasons. Probably 25–50% of GI malpractice claims are related to the procedures that we perform. The most common reasons are failure to diagnose in that we do a lot of colonoscopy and endoscopy. If we miss something, there's a failure to diagnose and that can sometimes lead to a malpractice case or a failure of the procedure related to complications. Most of the complications that occur though, obviously, are known risks of the procedure, but in the event where informed consent was not thorough or documented properly, there's always the chance of a malpractice case because the complication was not expected as a possible consequence of the procedure.

Dr. Buch:
Thank you. And what's the current malpractice situation for PAs and APRNs who work for us?

Dr. Weinstein:
You know, in my experience, our advanced practice providers, nurse practitioners, and PAs are covered under the malpractice policies for the physicians, and that's partly related to the fact that they are employees of the practice and they practice under the supervision of a gastroenterologist. Now, that supervision sometimes is loose and only as-needed, but, in fact, they are employees of the practice and therefore are expected to be supervised even when it may not be necessary for a particular issue.

Dr. Buch:
Are there certain situations where you're concerned about PAs and APRNs practicing along with you and creating a malpractice environment?

Dr. Weinstein:
Now, as I said, it's really the supervision, so ultimately, it is the practice's responsibility and the supervising physician's responsibility to monitor the care of patients, and you want to make sure that the recommendations, the orders, the follow-up with patients is reviewed and that physicians ultimately are being responsible for the care that the patients are getting. If you are not monitoring correctly and there is an untoward event, well, the physician will be sued along with the practice and the employee may get named, but it's ultimately the practice that's responsible.

Dr. Buch:
Thank you for clarifying that. And if we turn our attention to the use of electronic medical records, can you tell us how that can lead to malpractice claims?

Dr. Weinstein:
So we live now in this realm of permanent electronic medical records. Medical records, therefore, create documentation that is permanent, and it can either help in a malpractice situation, it can help verify that certain things happened, but it can also verify that certain things didn't happen, so EMRs are that double-edged sword: the documentation that can protect you, the documentation that can send you down the road to an untoward malpractice outcome.

The one thing I'll say is that in the event that there is an incident, one of the things you have to do early on is sort of lock down the medical record to make sure that if there is an incident that any additions or subtractions or changes to the medical record are closely monitored and that access to the medical record is locked down so that information is siloed within the practice.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Michael Weinstein about medical malpractice in gastroenterology.

So Dr. Weinstein, how much liability insurance should a gastroenterologist carry?

Dr. Weinstein:
It's more or less defined by the state that you live in as to what are the minimum levels that you must carry. The amounts of insurance that we carry depend upon where your primary practice is located. In Maryland, the physicians carry 1 million/3 million. I think most people understand that's 1 million per case, 3 million per year. You want to carry enough malpractice insurance that you're covered based upon your particular location.

Dr. Buch:
And what can you tell us about a consent to settle clause in the malpractice world?

Dr. Weinstein:
So consent to settle clause is often included in a malpractice policy, and that means that the carrier must obtain your written permission before they can settle a case on your behalf. And we all appreciate that any malpractice settlement, even for a hundred dollars, is reportable to the National Practitioner Data Bank, and physicians in general are reluctant to settle cases because they know that that information is going to be available in the public record for many, many years as searchable, and having a malpractice case go against you is not a good marketable finding. So if a malpractice carrier wants to settle a case, consent to settle means they have to have your permission. There are nuances to that because if the settlement is towards the higher end of your coverage, it actually may be that the physician wants to settle but the carrier doesn't want to settle because the carrier's risk is the maximum of your policy, and if the

settlement is close to the maximum of the policy, the insurance carrier may not want to settle because they figure, well, the most we can lose is the top of the coverage. Anything above that is the responsibility of the physician. So consent to settle sometimes can work in both directions. You have to also recognize that in a malpractice suit, the physician has defense counsel that is defending the physician and supporting the physician, and the carrier's interest are not necessarily a hundred percent aligned with the physician, so it's very important for physicians to make sure that they get a choice in their defense counsel and that they feel that they are represented correctly and that their individual interests represented in the case, not necessarily identical to the interests of the malpractice carrier.

Dr. Buch:
Thanks for clarifying that. So moving on from there, what are the risks and benefits of setting up a medical professional liability company?

Dr. Weinstein:
So captive insurance programs can fit the need more specifically of the specialty and the physician group. A couple years ago the Digestive Health Network, which is an outcropping of our advocacy association, developed a medical insurance captive, GastroAssure, as a medical professional liability platform for independent gastroenterology practices, and that allows the program to be designedfor gastroenterologists specifically and not general medical malpractice, which may or may not fit our specialty as well because of the procedural nature of our specialty and because of the limitations and the performance of what we do compared to other specialties. So we've designed a platform, with a national insurance company, Curi, that offers independent practices liability coverage similar to what they might get in a commercial liability carrier, but this grants the practices more access to stabilized and lower premiums and more controlled administrative costs.

Anybody who wants information about a captive insurance company can easily Google and find out how a medical insurance captive works, but the premiums that physicians are paying are basically self-insured. Now, we're not self-insured for the total cost because we obtain reinsurance, so the physicians are able to take the band of coverage at the bottom end, reinsure for costs higher than that, and then if the experience is good, then the excess premiums are retained by the owning physician groups of the captive. Captives are a very interesting way to actually not only control things like the way the administrative costs are spent but actually accumulate an asset from unspent premium dollars.

Dr. Buch:
That's great. Before we close, Dr. Weinstein, what can we do as clinicians to help reduce the risk of malpractice with our patients?

Dr. Weinstein:
I think the one area that I think we probably are not very good at is informed consent and documenting informed consent. You do dozens and dozens of procedures, and sometimes doing informed consent gets boring and repetitive, and I'm not sure that we do it completely. It's important to have both written information and make sure that the conversations and the patient's understanding of the informed consent is clear and documented within the electronic medical record. We use a video online tool to help with informed consent that the patient must watch before procedures. It's not long, it's about 12 minutes, and it requires the patient to watch an explanation of the procedures that we do that goes over the risks and the potential complications. And because it's electronic, it actually verifies that the patient watched the information, and it's forensically possible to determine from what computer and what time the patient watched the informed consent, and that hopefully will help decrease at least a third or some of thereabouts the malpractice cases that tend to hinge on whether or not complete informed consent was performed.

Dr. Buch:
Those were some wonderful insights, and that brings us to the end of today's program. I want to thank my guest, Dr. Michael Weinstein, for a great discussion. Dr. Weinstein, it was a pleasure speaking with you today.

Dr. Weinstein:
Well, I really appreciate the opportunity.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening and see you next time.