Medical Leader	
Medical Expert	☐
Communicator	•
Advocate	•
Scholar	
Professional	•
Collaborator	
Manager	•

Holey Colonoscopies

2013 Q2a

You are the Director of Medical Services for a 200 bed regional hospital. There is one gastroenterologist in the town who is also a VMO at the hospital. Most of the colonoscopies at the hospital are done by the 4 surgeons who visit the hospital. The gastroenterologist comes to you and says that the standard of colonoscopies provided by the surgeons is poor, and there are too many bowel perforations. You are aware that there have been 2 perforations over the last 3 years. She demands some action to "keep patients safe".

Two days after the gastroenterologist came to see you, you discover that there has been another bowel perforation recently. The incident came to your attention because the patient safety officer heard a complaint from the social worker who passed on a complaint from the patient. She had been discharged 5 days after her elective colonoscopy and emergency laparotomy for perforation and has now been at home one week and has posttraumatic stress symptoms. She has a long history of anxiety and depression. She has complained to the social worker that no-one told her what happened to her, or why she was in hospital so long. No follow up had been arranged.

You subsequently discover that the overall bowel perforation rate from colonoscopy for the hospital over the last 3 years was 1.5 per 1000, and the benchmark acceptable rate is 1 per 1000.

How will you manage this situation?

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Three (3) Core Elements

1. Individual and collective patient safety
2. Assessment and management of clinical performance
3. Systems and procedural monitoring and improvement.

Patient who complained comes first. Ensure that appropriate support and follow up has been arranged. Review file and arrange a meeting with the patient for open disclosure/clinical disclosure. Lack of communication may be a clinical failure by itself, irrespective of surgical care. Ensure clinical incident recorded and arrange appropriate clinical incident review.
Arrange to get data to describe quality of service. Is this a real problem?
May need to get advice as to how to measure quality in colonoscopy (perforation rates, caecal intubation rate, positive biopsy data,) This advice may come from external expert.
Literature search reveals Australian standards with acceptable perforation rates for interventional and non-interventional colonoscopies.
Identify individual cases with complications and review files, check who did procedure.
Calculate perforation rate for whole unit and for individual surgeons. Be aware of the random effect of low numbers, use statistical analysis to put confidence intervals around calculated rates if possible.
Approach to the patient with the recent perforation raises questions about standards of care with communication and also reporting of clinical incidents.
Good candidates will identify that a culture of poor communication and poor reporting means that clinical incident and patient coding data may be incomplete, and that a full chart audit may be the only way to get accurate information. Consider manual chart review of all patients who remained in hospital for > 24 hours post colonoscopy
Options to remediate poor practice by experienced colonoscopists are limited. At the elbow observation by a gastroenterologist may reveal technical problems but is professionally challenging to arrange.
Case selection may be important. Some very fragile patients may be better off having a CT colonogram rather than a colonoscopy is possible.
If outcomes are poor and do not meet a minimum standard of safety, and there are no acceptable options for improving the safety of the service, then limiting the scope of practice of some practitioners should be considered.