Your office manager interrupts you between patients and says, “You need to read this.” The letter you are handed says a complaint has been filed against you at the Texas Medical Board (TMB). You may instantly experience physical discomfort, or even feel like you were punched in the stomach.

If the alleged violation(s) is serious, some physicians may initially feel that this is the proverbial straw that breaks the camel’s back — that there are simply too many negatives in the practice of medicine and that they want to find a way out of this profession as soon as possible. Fortunately, the vast majority of those physicians eventually rethink that position. The purpose of this article is to give you a framework for re-evaluating that decision and for surviving the emotional turmoil caused by a TMB investigation.

How do you successfully manage the adverse impact that this process will have on your life for the next year or longer? First, you need to recognize and understand the array of emotional responses you may experience. Implicit in this first step is an acknowledgment that you are most likely going to be emotionally affected by the process in a significant way.

In our law practice, we have observed that physicians who are notified that they will be investigated by the TMB go through an emotional process similar in many ways to the recognized stages of grief.

**Surviving a TMB investigation**

by Stacey J. Simmons, JD and Dan Ballard, JD

Often, your first reaction will be denial that there was any impropriety in the care you provided to your patient. This emotional reaction frequently leads to internally downplaying the significance of what can happen when the TMB investigates you or your patient care. Thus, you may fail to respond to the situation with an appropriate level of concern and attention.

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Many physicians make the mistake of acting as though the complaint against them is so frivolous that they merely need to explain their care and then the TMB will surely see the lack of merit in the complaint and dismiss it. Moreover, you may have the impression that the process is informal and collegial, but in truth, this is serious business. It is very important then that you obtain an attorney’s expertise early to respond to the Board and present the information in a persuasive and appropriate way. It is essential to capture the opportunity to make the best possible first impression to the Board.

Any attorney who represents physicians before the Board can relate instances where he or she was hired late in the process, after the physician has filed an inadequate response to a patient’s complaint. The physician will often tell the attorney, “I just didn’t think the Board would take this complaint seriously.” If you are insured by TMLT, you have coverage that will reimburse you for reasonable legal expenses and expert witness fees incurred in defending a TMB complaint (up to $25,000 per policy period, subject to the terms and conditions of the policy). This coverage is provided to help you financially cope with what is already a difficult and emotional situation. We encourage you to take advantage of this resource.

You should also be aware that if the Board has concerns about your medical care, but feels the case is not really clear cut, they may reprimand you for poor documentation. TMB rule violations regarding chart documentation are frequently found in patients’ charts. (For details on these rules, please visit http://www.tmb.state.tx.us/rules/rules/bdruules_toc.php.) These factors make it very difficult to justify “going it alone” when you are called upon to defend yourself against a Board complaint.

Anger often follows denial, and can be a double-edged reaction. It may begin as anger directed at the patient, family member, or other individual who has filed the complaint, leading some physicians to feel “victimized” by ungrateful patients. Unfortunately, even the more philosophical physician who may have gone through the TMB’s complaint process before is often left with a bad taste about the entire medical care system. In addition, some physicians who have gone through a Board investigation based on a patient complaint retain some degree of anger which may change how they feel about their patients. They should seek assistance in working through this anger.

The second phase of anger comes later as the Board, rather than the patient or complainant, becomes the active party. It is the very rare physician who, at the end of the investigation process, feels the complaint was warranted, the process was productive, and the result was fair.

One of the most disturbing parts of the process is that you will not be told the specifics of the complaint until several months into the process. Frequently, the TMB simply notifies you that some unidentified person or the TMB itself has filed a complaint regarding your care of a particular patient. The TMB is not required to provide you with a copy of the medical records they have obtained from other providers or with a copy of their experts’ analysis of your care until 30 days before the Informal Settlement Conference (ISC) hearing. The Board can take several months to develop the case against you before telling you the specific allegations and criticisms. But you will have only three weeks after receiving this information to respond! Frequently, it is also necessary to have your care reviewed by experts on your behalf and to provide their reports to the TMB. This can be difficult to accomplish in the time you are given. Once physicians learn of this timetable, they generally wonder why the playing field does not seem level. This is one reason why it is very important to seek legal assistance at the time you are first notified of the complaint.

Another frustration you may experience concerns obtaining medical records that you may need in order to defend yourself. The TMB obtains whatever records they deem relevant to the complaint. You do not have the same access to medical records from the patient’s other health care providers that you may need to defend yourself before the Board. If you request the TMB’s assistance in securing records, you may be disappointed. However, your attorney will make every effort to get the information needed to defend your conduct.

Probably the best emotional defense for this perceived lack of fairness is simply to go in with your eyes open. While anger is a natural response, it can hamper your ability to effectively address the allegations that have been brought against you. Competent counsel can be of great assistance in helping you develop and present your defense to the Board.

If the case is taken to an ISC hearing, you may worry that some form of sanction or disciplinary action from the Board could occur. Concerns about damage to your professional reputation become a major issue in cases where it appears likely that the Board is going to issue some form of disciplinary action (e.g., in the form of an “Agreed Order.”) The depression that can flow from this becomes a substantial factor in the lives of many physicians in the months leading up to and following a Board hearing.

Probably the most difficult thing to deal with is the publicity that may follow, either in the TMB’s newsletter or other media, if even a minor sanction was issued against you. You may worry that even a relatively minor complaint may affect your reputation; and this can lead to considerable anxiety.

Like lawsuits, some negative outcomes from a TMB complaint will be reported to the National Practitioner Data Bank (NPDB). Fortunately, however, only a small number of people — including hospital credentialing committees and insurance companies — have access to the NPDB. Members of the public do not have access. Typically, those who do have access understand that complaints are being filed and physicians are being disciplined with
greater frequency. Having an Agreed Order in your NPDB file is not looked upon with the same suspicion as it probably once was.

It is important to note that a complaint against a physician is confidential and will remain so in the event that the complaint is dismissed at or before the first hearing stage (i.e., at the ISC). There is a common misconception that the Formal Complaints mentioned in the TMB newsletter are published simply on the basis of a complaint letter by a patient. To the contrary, these published Formal Complaints have already gone through the initial hearing stage (i.e., an ISC), wherein the complaint was not dismissed, and the physician refused to accept the terms of the Agreed Order that was offered after the hearing.

It is also worth noting that, as of Fall 2007, the TMB made a significant change regarding how it releases information to the public about “minimal statutory violations.” These actions, although still public and part of the physician’s record, will not be listed in TMB press releases or the TMB newsletter by physician’s name. Only the numbers of such violations will be listed. “Minimal statutory violations” are based on violations that do not involve the standard of care and are for rule violations such as failing to release medical records in a timely fashion, failure to obtain required CME, or failure to timely sign a death certificate. (For more information, please see the Fall 2007 issue of Texas Medical Board Bulletin, available at http://www.tmb.state.tx.us/news/newsletters.php.) Following the publication of a Board order, some physicians report a great deal of anxiety about whether specific colleagues, friends, and patients had found out about it. This usually leads to a more general concern about whether the sanction will actually have a serious financial impact on them due to decreased referrals from colleagues or fewer self-referrals by patients. For example, a surgeon would have a legitimate concern that a publicized Board order based on a surgical mishap could have a negative effect on his or her referral base. In our experience, a pure “standard of care” complaint has a higher likelihood of a favorable outcome than many other types of investigative actions by the Board (such as self-prescribing, substance abuse, and boundary issues).

Perhaps the most difficult emotional aspect of dealing with a Board complaint is realizing that you may need to accept a sanction or other outcome that you feel is entirely undeserved. Although many physicians begin the process saying and truly believing “I’ll fight this until the bitter end,” in our experience the vast majority of physicians who receive an adverse recommendation by the Board’s hearing panel eventually (typically within a few weeks) decide to compromise and accept some degree of sanction from the Board. Instead of drawing a line in the sand, it is best to reconcile yourself to the situation as it presents itself, considering how defensible your medical care was, and what the potential long-term ramifications of accepting an Agreed Order may be. Making an informed and rational decision will generally leave you with the best outcome under the circumstances.

In our years of defending physicians against TMB actions, we have found that for physicians struggling with whether to accept a Board order, it is helpful to understand that if your peers hear about your Board order, they will likely understand that in the current environment, the same thing could happen to them or any number of competent physicians. While your patients and other members of the public cannot necessarily be expected to share this view, most of them may not ever know about it. It may be very consoling to know that your peers actually understand what it is like to be in your shoes. More than likely, they feel great empathy for what you are going through.

In summary

When faced with a TMB investigation, consider the following:

1. Acknowledge that any TMB complaint is significant. Promptly obtain competent legal help and invest the time necessary to develop a proper defense. TMLT’s Claim Department can provide assistance to you if you need it.

2. Realize that anger is not productive. Talk openly about your anger with your attorney. Your family and colleagues may be counted on to assist you through any emotional turmoil that you may be experiencing. However, follow your attorney’s advice regarding those in whom you may confide. Leave your anger at home on the day of your Board hearing.

3. Be comforted by the fact that, if you already have a good professional reputation, it will likely remain intact.

4. Defend yourself and re-evaluate your strengths and weaknesses at each step in the process. Try to avoid drawing lines in the sand.

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Asset protection —

by Laura Brockway, ELS

Editor’s note: The information provided in this article is not to be construed as legal advice and should not be relied upon without specific consultation with a professional.

It’s an unpleasant fact to face — asset protection is still a concern for Texas physicians. Though the medical liability reforms of 2003 have succeeded in reducing claims, lowering insurance rates, and bringing more physicians to Texas, the reforms did not eliminate the need for physicians to protect their assets. Physicians are still being sued, and with any lawsuit comes risk to a physician’s personal assets. If a judgment exceeds policy limits or if a cause of action falls under the policy exclusions, a physician’s personal assets or a practice’s accounts receivables may be exposed. Without advanced planning, these hard-earned assets could be lost. The solution — asset protection.

“Just as you encourage patients to take preventive measures to ward off health problems, it is prudent to organize your financial affairs and assets to guard against risks in advance,” says Austin attorney Ken Vanway.

For Fort Worth attorney Marvin Blum, asset protection is one part of the overall financial and estate planning process. “You build a structure to protect assets from being taken by future creditors, especially if disaster strikes and there is a substantial judgment against the physician that exceeds his or her insurance limits,” he says.

Why physicians need asset protection

According to Mr. Blum, medical liability is just one risk physicians face. “Physicians can also be sued for other reasons — if a patient is injured in the office or parking lot, slip-and-fall claims,” Mr. Blum says. “Physicians have a reputation as having deep pockets. They are perceived as wealthy. If one party is perceived as having deep pockets, they are more likely to be sued even if it’s an automobile accident.”

Many physicians believe the threat of an excess judgment or jury verdict was mitigated by the medical liability reforms of 2003. According to Mr. Blum and Mr. Vanway, physicians should still be concerned about asset protection for several reasons.

The 2003 reforms placed caps on non-economic damages only. Economic damages — which can include past and future medical expenses and lost wages — were not capped. “If the plaintiff was a high wage earner, the judgment could be substantial,” says Mr. Vanway.

Additionally, the reforms only affected medical liability claims. Other types of liability claims are not subject to the caps on non-economic damages. Mr. Blum also points out that the protection afforded by the caps could be short-lived. “There is no guarantee these reforms will stick. They continue to be controversial, and it is very likely the legislature will be pressured to either raise the cap or repeal the law,” Mr. Blum says. “It’s important for physicians to have asset protection strategies in place before that happens.”

Vulnerable areas

“When deciding on an asset protection plan, we look at a client’s financial statement to first determine what is protected by statute. What cannot be taken away from you,” says Vanway. These “protected assets” can include:

• The physician’s home, if he or she has lived there longer than 40 months. The Texas Property Code provides that a “homestead” is exempt from the claims of the owner’s creditors, other than valid encumbrances properly fixed on the property. In Texas, this homestead protection was unlimited, with no dollar limit on the value of the property. However, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 placed limits on the unlimited Texas homestead exemption. The unlimited Texas exemption only applies if the homestead has been owned for more than 40 months. If the home has been owned for a shorter period, the homestead exemption is limited to $125,000.

• $30,000 in personal property for a single adult and $60,000 in personal property for a family. The personal property eligible for this exemption includes home furnishings, family heirlooms, vehicles, personal property used in a trade or business, and jewelry (not to exceed 25% of the applicable dollar limitation.)

• Qualified retirement plan benefits and IRAs are generally exempt from creditors. The 2005 Bankruptcy Reform Act limited this exemption to $1 million per individual ($2 million for a husband and wife.) IRAs are only exempt to the extent that the contributions were tax deductible when made.

• Annuities and life insurance — Texas has an unlimited exemption for insurance benefits, employer-provided annuities, and annuity contracts purchased by individuals.

“All other assets — other real estate, brokerage accounts, interest in a practice, bank accounts, notes, are subject to creditors,” says Mr. Vanway.

One particularly vulnerable area for physicians — their accounts receivables, which may represent their largest business asset. “A large accounts receivable balance presents an attractive target to a creditor. It is relatively easy for a creditor to collect a judgment because the court can appoint a receiver to open the mail and take the payments made on the accounts receivable balance until the judgment is satisfied,” says Mr. Blum.

“In a multi-physician practice, if any one physician has a judgment against him or her, all of the practice’s accounts receivables are exposed because they are an asset of the practice,” says Mr. Vanway. This applies even for a judgment against a physician who is no longer with the group.

Accounts receivables are susceptible even if the physician practice operates with an entity that limits liability. “If the doctor is the sole owner of his entity, the creditor can get a judgment against the entity too, which gives the creditor access to the accounts receivable,” says Mr. Blum. “Also, if the doctor operates as a sole proprietor and owns the accounts receivable personally, then a creditor who has a judgment against the doctor can take the doctor’s accounts receivable.”
Physicians who are married and hold their assets as community property should be aware that 100 percent of community property is vulnerable in a claim against either spouse. “Many physicians believe that only their half of the community property can be taken. But a creditor can take 100 percent of the property, wiping out both the physician and the spouse,” says Mr. Blum. (Texas is one of 10 states that follow the community property system, meaning that property acquired by spouses during a marriage is viewed as one total “community” of property.)

**Strategies**

Fortunately, a number of strategies can be employed to protect a physician’s vulnerable assets.

“The process can go from simple to very complex. I usually lay out the continuum to clients, and they pick how far we go by what it takes for them to sleep well at night,” says Mr. Blum.

An example of one simple strategy is partition planning which can be used to protect community property. “With partition planning, the husband and wife agree to partition community property into separate halves. This is a simple document that protects the separate property of the innocent spouse from exposure to claims against the other spouse,” says Mr. Blum.

Physicians can also take advantage of state law exemptions and pay off their home mortgage, if they have owned the home longer than 40 months. Another option is to put money in qualified retirement plans, though the protection is limited to $1 million per individual. Physicians can also purchase life insurance or annuity products, which are exempt from creditors’ claims.

Physicians can also set up trusts for children or grandchildren. “By setting up trusts, physicians can gift assets into them and get them off their balance sheet,” says Mr. Vanway.

One strategy along the middle of the complexity spectrum includes creating a Family Limited Partnership. “One way to protect personal assets is to create a Family Limited Partnership [FLP] and transfer title of those assets to that entity. If there is a judgment against the physician, the assets in this entity cannot be touched,” says Mr. Vanway.

Under an FLP, a creditor holding a claim against a physician has limited rights to satisfy that claim with respect to the partnership interest held by that person. “Creditors can end up waiting and waiting for years. This tends to make creditors frustrated and inclined to settle for less than the judgment amount,” says Mr. Blum. “It also makes the personal injury attorney less likely to take the case because it is more difficult for them to recover their fees and expenses.”

To protect accounts receivables, Mr. Blum implements a strategic medical accounts receivable transfer or SMART plan. “For

**Asset protection tips**

**How to find an attorney**

Both Mr. Vanway and Mr. Blum recommend that physicians employ an attorney who is Board Certified in Estate Planning and Probate Law and who has extensive experience in this area of law.

“Physicians should look for a board certified attorney with good references and 10 or more years of experience in asset protection,” says Mr. Vanway.

**Time involved**

According to Mr. Blum, the time involved in setting up a plan depends on the complexity of that plan. For the simplest plans, it is a 3-meeting process with the attorney. At the first meeting, which would last about two hours, the physician and attorney discuss the physician’s assets and financial situation. The attorney would then analyze this information and make recommendations. These recommendations would be reviewed at a second meeting, which would take about one hour. The attorney then begins to implement the recommendations, and there is a third meeting to review and sign documents. This meeting may take about two hours. For more complicated plans, it could take several meetings.

To prepare for the initial meeting, the physician needs to bring a list of his or her assets. The physician’s CPA or financial planner can help collect this information.

**Cost**

How much an asset protection plan will cost also varies with the complexity of the plan. Mr. Blum estimates the cost for partition planning and using state law exemptions to be $2,000. The cost to create trusts could be $3,000. The cost to create an FLP and implement a complex plan could range from $5,000 to $10,000. According to Mr. Vanway, the investment in an asset protection plan is generally a one-time expenditure and will be fully or partially income tax deductible.

“The cost is very individualized and clearly this is a situation where you get what you pay for,” says Mr. Blum.
Conditional care —
barriers in mental health care

Course author
Robin Desrocher is a risk management representative at TMLT.

Disclosure
Robin Desrocher has no commercial affiliations/interests to disclose related to this activity.

Target audience
This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement
Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. TMLT designates this educational activity for a maximum of 1 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

Ethics statement
This course has been designated by TMLT for 1 hour of education in medical ethics and/or professional responsibility.

Directions
Please read the entire article and answer the CME test questions. To receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Please allow four to six weeks from receipt of test and evaluation form for delivery of certificate.

Estimated time to complete activity
It should take approximately 1 hour to read this article and complete the questions.

Objectives
At the conclusion of this educational activity, the physician should be able to:

1. discuss the prevalence of mental health disorders in the United States;
2. list the two most common barriers to receiving mental health care;
3. identify the four sectors of the mental health services system; and
4. define parity and discuss the recent federal legislative attempts to achieve it.
Introduction

Patients are continuously challenged by the task of navigating our health care system. They can spend endless hours making phone calls to schedule appointments and diagnostic tests. To make things more difficult and inconvenient for patients and caregivers, many health plans outline specifically where they can go for care and treatment. With so many different health plans in existence, it is difficult to know which set of rules apply. If patients do not follow the rules, there will be consequences. For those living with a mental illness, this task can be more difficult, and the consequences can be devastating.

With the help of modern medicine, Americans are living longer. Many diseases that were once a death sentence upon diagnosis are now treatable and even curable. Even after years of research about the association between the mind and body, mental health is still widely misunderstood. People will readily discuss the physical problems affecting their lives but will go to great lengths to avoid talking about problems that may indicate a mental health problem exists.

“The general reluctance of patients to seek care for mental health problems complicates the diagnosis of mental illness. Survey results show that 40 percent of patients with major depression do not want or perceive the need for treatment. Patients consistently underreport emotional issues to their physicians.”

Definitions

Mental health is defined as “the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.”

Mental illness “refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.”

Treatments for mental illness exist and can improve quality of life. Patients report an improvement in their overall well being once they open up with their physicians and discuss the problem. “Effective interventions help people to understand that mental disorders are not character flaws but are legitimate illnesses that respond to specific treatments, just as other health conditions respond to medical interventions.”

Patients may be unaware of the treatment options and the many possible ways of obtaining treatment. “All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence.”

Prevalence

Estimates concerning the prevalence of mental health disorders come from a variety of sources.

• In Mental Health: A Report of the Surgeon General, it is estimated that approximately 15 percent of the adult population in the United States use mental health services in any given year.

• Statistics from the National Institute of Mental Health estimate that 26.2 percent of Americans over the age of 18 suffer from a diagnosable mental disorder in a given year. “When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people.”

• Studies show that the frequency of mental disorders in general practice varies from 11 percent to 36 percent. “The prevalence of major depressive disorder in the primary care setting has been estimated at between 4.8 percent and 8.6 percent.”

“Psychiatric problems are a major health issue. Globally, major depression ranks fourth in terms of disability-adjusted life years and may soon be the second leading cause of disability worldwide. According to the Surgeon General, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer. It is estimated that major depression in the United States is associated with 20,000 suicides and $47 billion in health care costs annually. Depression produces as much suffering and disability as does heart disease or diabetes.”

Mental illness through the lifespan

Childhood

“Childhood is characterized by periods of transition and reorganization, making it critical to assess the mental health of children and adolescents in the context of familial, social, and cultural expectations about age-appropriate thoughts, emotions, and behavior.”

According to the Surgeon General’s report, approximately one in five children and adolescents experience signs and symptoms of a mental illness in a given year. Effective psychosocial and pharmacologic treatments exist for many mental health disorders in children, including attention-deficit/hyperactivity disorder, depression, and the disruptive disorders. Additionally, interventions, such as parent-education programs and nurse home visits, have been shown to be effective in reducing the impact of risk factors for mental disorders in children. “Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care.”

Adults

Adulthood is a time when people build close personal relationships and develop productive careers. Mental illness can disrupt this, leading to lost productivity, unsuccessful relationships and significant dysfunction. Mental illness in adults also significantly affects children in their care. “An estimated 26.2 percent of Texans aged 18 years and older and about 1 in 4 adults suffer from a diagnosable mental disorder in any given year. Mental disorders are the leading cause of disability for individuals aged 15-44.”
The Surgeon General’s report states that anxiety, depression, and schizophrenia present special problems in this age group. Anxiety and depression contribute to the high rate of suicide in adults. In addition, substance abuse is a major co-occurring problem for adults with mental disorders.1

“Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing, and managed care.”1

Older adults

“Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will present special problems in this age group:

• dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life;

• depression contributes to the high rates of suicide among males in this population; and

• schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.”1

The Surgeon General’s Report calls primary care practitioners a “critical link” in diagnosing and treating mental disorders in older adults. “Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.”1

Postpartum depression

Postpartum mood changes can range from transient blues immediately following childbirth to an episode of major depression.1 Postpartum mental health care has been a neglected aspect of women’s health care. This is evident in the limited data available related to postpartum mental health. Missed opportunities for enhancing the health care of postpartum women still occur during routine postpartum care today. In 2005, the Texas legislature passed a law requiring hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation or at delivery to provide the woman and the father of the infant or other adult caregiver for the infant with a resource pamphlet that includes information on postpartum depression, shaken baby syndrome, immunizations and newborn screening. The brochure is maintained by the Texas Department of State Health Services, and is available in English and Spanish at http://www.dshs.state.tx.us/mch/Parents_of_newborn.shtm.

The law also requires that it be documented in the patient’s chart that she received this information, and the documentation must be retained for a minimum of five years. “It is recommended that the information be given twice, once at the first prenatal visit and again after delivery.”5

Barriers to treatment

“Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment. Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.”1

Stigma

“Stigma erodes confidence that mental disorders are valid, treatable conditions. It leads people to avoid socializing, employing, or working with, or renting to or living near persons who have a mental disorder, especially a severe disorder like schizophrenia. Stigma deters the public from wanting to pay for care and, thus, reduces the consumer’s access to resources and opportunities for treatment and social services.”1

According to an article from Current Opinions in Psychiatry, people with mental illness identify employment discrimination as one of their most frequent stigma experiences.

“One in three mental health consumers in the United States report being turned down for a job once their psychiatric status became known and in some cases, job offers were rescinded when a psychiatric history was revealed.”6

Surveys of U.S. employers show that half of them are reluctant to hire someone with a history of mental illness or who is currently undergoing treatment for depression. Approximately 70 percent are reluctant to hire someone with a history of substance abuse or someone currently taking antipsychotic medication.6

“In order to avoid workplace stigma and discrimination, employees with mental health problems will usually go to great lengths to ensure that coworkers and managers do not find out about their illness, including avoiding employee assistance programs and shunning effective treatment options. Indeed, the majority of employees who have mental health problems will fail to receive appropriate treatment. For example, only about a third of employees with depression will consult a mental health professional, physician or employee assistance program and as few as one in 10 of those who report occupational impairment will take medication to address the problem. Yet, the majority of those who are appropriately treated for depression will manifest improved work performance and reduced disability days sufficient to offset employer costs of treatment.”6

Access to care

“Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services.”1

According to the Surgeon General’s report, mental disorders and mental health problems in the U.S. “. . . are treated by a variety of caregivers who work in diverse, relatively independent, and loosely coordinated facilities and services — both public and private. . .” About 15 percent of all adults and 21 percent of children and adolescents use services in the U.S. mental health service system.7

The report describes the mental health services system as having four major sectors:

• The specialty mental health sector consists of psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers. Most specialty treatment is provided in outpatient settings and acute hospital care is provided in psychiatric units of general hospitals or in private psychiatric hospi-
Barriers in mental health care

tals and residential treatment centers. Public facilities include state/county mental hospitals and multiservice mental health facilities. Less than 6 percent of the adult population and about 8 percent of children and adolescents use specialty mental health services in a year.

- The general medical/primary care sector includes general internists, family physicians, pediatricians, and advanced practice nurses in office-based practice, clinics, acute medical/surgical hospitals, and nursing homes. More than 6 percent of adults in the U.S. use the general medical sector for mental health care, averaging 4 visits per year. This is much lower than the average 14 visits per year found in the specialty sector. Only about 3 percent of children and adolescents contact their primary care physicians for mental health services.

- The human services sector consists of social services, school-based counseling services, residential and vocational rehabilitation services, criminal justice services, and religious professional counselors. Five percent of adults in the U.S. use these services. School mental health services, a major source of care, are used by 16 percent of children. Services in the child welfare and juvenile justice system serve about 3 percent of children.

- The voluntary support network sector includes self-help groups. About 3 percent of U.S. adults use these services. "

“Given that 28 percent of the population have a diagnosable mental or substance abuse disorder and only 8 percent of adults both have a diagnosable disorder and use mental health services, one can conclude that less than one-third of adults with a diagnosable mental disorder receives treatment in one year. In short, a substantial majority of those with specific mental disorders do not receive treatment.” 7

Access to care can be limited for a number of reasons. Availability of mental health care professionals can severely limit treatment options. Compounding this, mental health treatment is more personalized than any other form of medical treatment, making it much more difficult to find a suitable source of treatment for each patient.

“A key disparity often hinges on a person’s financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance.” 1

The role of primary care

Physicians in all areas of practice will encounter patients with varying degrees of mental health disorders that may affect their effective diagnosis and treatment of a physical complaint. This challenge is especially prevalent in the primary care practice for family physicians, pediatricians, ob-gyns, and internal medicine physicians. “The general medical sector has long been identified as the initial point of contact for many adults with mental disorders; for some, these providers may be their only source of mental health services.” 7

Information about mental health care delivered in physicians’ offices is available through the National Ambulatory Medical Care Survey (NAMCS), conducted by the Centers for Disease Control and Prevention (CDC). In 2005, an estimated 963.6 million visits were made to office-based physicians. Of those visits, an estimated 29.6 million were for symptoms referable to psychological and mental disorders. 8

“One study demonstrated that only 20 percent to 30 percent of patients with emotional/psychologic issues reported these to their primary care physicians. Many patients somatize their psychologic issues. One in three patients who go to the emergency department with acute chest pain is suffering from either panic disorder or depression. Eighty percent of patients with depression present initially with physical symptoms such as pain or fatigue or worsening symptoms of a chronic medical illness. Although this type of presentation creates a challenge for family physicians, these patients are not likely to seek care through the mental health system.” 2

Another difficulty faced by primary care physicians is that their patients typically seek care for a variety of reasons. “Unlike the psychiatric professional who sees patients who accept the diagnosis and the need for treatment, the family physician has to identify mental health problems that are frequently obscured by patient reluctance to acknowledge the problem or by physical symptoms that mask the underlying problem.” 2

Parity

“Inequities in insurance coverage for mental health and general medical care — the product of decades of stigma and discrimination — have prompted efforts to correct them through legislation designed to produce financing changes and parity. Parity calls for equality between mental health and other health coverage.” 1

There have been widespread efforts to expand coverage for mental health care under traditional health insurance plans. According to the Surgeon General’s report, existing coverage plans are often very limited and do not provide enough care for the average mental health patient. The limits imposed often include annual limits on inpatient days, limits on outpatient visits, maximum lifetime limits, and annual limits for mental health care services.

“Concerns about the cost of care — concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses — are among the foremost reasons why people do not seek needed mental health care. While both access to and use of mental health services increase when benefits for those services are enhanced, preliminary data show that the effectiveness — and, thus, the value — of mental health care also has increased in recent years, while expenditures for services, under managed care, have fallen.” 1

“Federal legislative efforts to achieve parity in mental health insurance coverage date from the 1970s and have continued through to present times.” 7 The Mental Health Parity Act was passed in 1996 and implemented in 1998. This legislation prohibited the use of lifetime and annual limits on coverage that were different for mental and somatic illness.

Though this legislation was seen as an important first step in achieving mental health parity, several limitations were noted. “Companies with fewer than 50 employees or which offered no mental health benefit were exempt from provisions of the law. The parity provisions did not apply to other forms of benefit limits, such as per episode limits on length of stay or visit limits, or copayments and deductibles, and they
did not include substance abuse treatment. In addition, insurers who experienced more than a 1 percent rise in premium as a result of implementing parity could apply for an exemption.”

Further efforts to enhance parity at the federal level have resulted in the Mental Health Parity Act of 2007 (S. 558). The legislation “amends the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act to require a group health plan that provides both medical and surgical benefits and mental health benefits to ensure that: (1) the financial requirements applicable to such mental health benefits are no more restrictive than those of substantially all medical and surgical benefits covered by the plan, including deductibles and copayments; and (2) the treatment limitations applicable to such mental health benefits are no more restrictive than those applied to substantially all medical and surgical benefits covered by the plan, including limits on the frequency of treatments or similar limits on the scope or duration of treatment. [The legislation] Prohibits the plan from establishing separate cost sharing requirements that are applicable only with respect to mental health benefits.”

On September 18, 2007, the Mental Health Parity Act of 2007 was passed by the U.S. Senate. The legislation has been sent to the U.S. House of Representatives where it was referred to the Subcommittee on Health, Employment, Labor, and Pensions. Information on the Mental Health Parity Act of 2007 is available at: http://thomas.loc.gov/cgi-bin/query/D?c110:4:./temp/~c110oLigpw::

Privacy concerns
Concern about the disclosure of private health information exists in all areas of health care. There is even greater concern in the field of mental health. “An assurance of confidentiality is understandably critical in individual decisions to seek treatment for mental health disorders.” Although expansive state and federal laws protect the confidentiality of physician-patient interactions, potential problems exist.

• People’s willingness to seek help is contingent on their confidence that personal revelations of mental distress will not be disclosed without their consent.
• The U.S. Supreme Court recently has upheld the right to the privacy of these records and the therapist-client relationship.
• Although confidentiality issues are common to health care in general, there are special concerns for mental health care and mental health care records because of the extremely personal nature of the material shared in treatment.”

Risk management considerations
• Communication plays a key role in all aspects of patient care. Patients may not reveal information about their mental health until they feel that they can trust their physician. Utilizing the skill of active listening is one way of building that trust with patients and families.
• Patients certainly have the right to refuse treatment unless they pose a threat to themselves or others. When a patient who is not a threat refuses treatment, it is important for physicians to ascertain the reason for the refusal. Take this opportunity to ask more questions. Have you explained the problem in terms that the patient can understand? Are there specific obstacles that a patient must overcome in order to follow the recommended treatment plan? Does the patient fully understand the risks, benefits, and alternatives for the problem at hand? Will the recommended treatment pose a financial burden on the patient? Is the treatment covered under the patient’s insurance plan? Is religion or culture a factor in the treatment plan?
• Patients may not be refusing treatment because they do not want to follow your advice. Legitimate obstacles to accepting the treatment plan may exist. Documenting the patient’s decision to refuse treatment and the reasons for that refusal is another important aspect to consider. When approaching the treatment plan from the patient’s perspective, it may be necessary to alter the plan to increase compliance. An effective treatment plan is one that involves the patient whenever possible.

The future of mental health care
Advocates and consumers continue to push for moving mental health care into the mainstream of health. “Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.”

Assuring access and resource availability are key areas where public policy must be focused. Integrating mental health care with the rest of medicine will be a significant step toward improved care for patients suffering from these devastating illnesses.

Resources
Along with psychiatrists, mental health clinics, and emergency departments, primary care physicians will find it useful to maintain a comprehensive list of resources available in the community.

Advocacy, Inc.
Each state has a protection and advocacy
CME test questions

Instructions: Using black ink, read each question, select the answer, and then clearly mark your selection. Please fax the completed test and evaluation forms to the Risk Management Department, attention Rebecca Henson 512-425-5996. You can also mail the test and evaluation forms to the TMLT Risk Management Department, attention Rebecca Henson, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide on the CME evaluation form.

1. Once patients discuss their concerns regarding their mental health with their physician, they report:
   ○ a. an improvement in their overall well being
   ○ b. that their symptoms worsen
   ○ c. no change in their condition
   ○ d. none of the above.

2. Nearly half of all Americans who have a severe mental illness do not seek treatment.
   ○ a. true
   ○ b. false

3. How many Americans over the age of 18 suffer from a diagnosable mental disorder in a given year?
   ○ a. 10.3 million
   ○ b. 2 billion
   ○ c. 57.7 million
   ○ d. 7.7 million

4. Primary care physicians have long been identified as the initial point of contact for many adults with mental disorders.
   ○ a. true
   ○ b. false

5. The stigma associated with mental illness:
   ○ a. reduces patients' access to resources and opportunities for treatment
   ○ b. erodes confidence that mental disorders are valid, treatable conditions
   ○ c. leads to employment discrimination
   ○ d. all of the above

Statement of completion

I attest to having spent _____________ hours in this CME activity.

Physician signature ____________________________________________ Date __________________________

Barriers in mental health care
CME evaluation form
Please complete the following regarding the article, "Barriers in mental health care."
Please fax the completed evaluation with the CME test questions.

1. The objectives for this CME were met.  ☐ Yes  ☐ No

2. The material will be useful in my practice.  ☐ Yes  ☐ No

3. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain.
   ☐ Yes  ☐ No

4. How long did it take you to complete this learning activity?
   ☐ .5 hr  ☐ .75 hr  ☐ 1 hr  ☐ 1.25 hrs  ☐ 1.5 hrs

5. On a scale of 1 to 5, with 5 being the highest, how do you rank the effectiveness of this activity as it pertains to your practice?
   ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

6. What will you do differently in your medical practice after reading this article?


7. Suggestions for course improvement are:


8. Suggestions for future topics include:


Contact information

Name  __________________________________________

Address _________________________________________

Phone  __________________________________________

TMLT policyholder?  ☐ Yes  ☐ No

Barriers in mental health care
agency that receives funding from the Federal Center for Mental Health Services. Agencies are mandated to protect and advocate for the rights of people with mental illnesses and to investigate reports of abuse and neglect in facilities that treat individuals with mental illnesses.
512-454-4816
800-252-9108
www.advocacyinc.org

Mental Health America of Texas
The Mental Health America of Texas is a nonprofit organization that addresses key issues surrounding mental health and mental illnesses through collaborations, research, innovative programming, legislative campaigns, and public awareness initiatives.
512-454-3706
www.mhata.org

National Alliance on Mental Illness of Texas (NAMI)
The National Alliance on Mental Illness of Texas is a nonprofit organization that helps improve the lives of people affected by mental illness through education, support, and advocacy.
512-693-2000
800-633-3760
www.namitexas.org

The National Mental Health Consumer’s Self-Help Clearinghouse
Located in Philadelphia, Pa., the Clearinghouse helps consumers organize coalitions, establish self-help groups and other consumer-driven services, advocate for mental health reform, and fight the stigma and discrimination associated with mental illnesses.
800-553-4539
www.mhselfhelp.org

The Texas Department of State Health Services (DSHS)
To learn more about DSHS community mental health services that are available in your area, contact your local mental health authority. You will also be able to access the “crisis hotline,” which is answered 24 hours a day, seven days a week. To find the proper mental health authority, please visit: http://webdbs.dshs.state.tx.us/mhservices/ default.asp?strMHA=I

Texas Department of State Health Services Consumer Rights for Mental Health Services
For information on patient rights or to file a complaint:
512-206-5760
800-252-8154
TDD: 800-735-2989
www.dshs.state.tx.us/mhservices/MH-ConsumerRights.shtm

Texas Department of State Health Services Substance Abuse Services
For information about treatment and care of substance abuse disorders:
512-206-5000
866-787-8440
www.tcada.state.tx.us

Texas Federation of Families for Children’s Mental Health
A statewide, family-run network that provides support and information to families of children and adolescents with serious emotional, behavioral, or mental disorders.
512-407-8844
866-893-3264

Texas Health and Human Services Commission
For more information about admission, treatment, release, and patient follow-up in public or private psychiatric residential facilities
512-424-6500
800-252-8263
Local referral information line: 211
TDD: 512-424-6597
www.hhsc.state.tx.us

Texas Mental Health Consumers
Texas Mental Health Consumers is a nonprofit organization whose mission is to organize, encourage, and educate mental health consumers throughout Texas.
512-451-3191
800-860-6057
www.tmhc.org

References

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**asset protection . . . continued from page 5**

This, you borrow funds from a bank and then use the proceeds to purchase an asset that is exempt from creditor claims, such as an annuity. The receivables are pledged as collateral for the loan and cannot be reached by creditors,” Mr. Blum says.

**Successful asset protection**

According to both Mr. Blum and Mr. Vanway, the key to successful asset protection is to do it early. It is very difficult to protect assets against existing claims, but it is relatively easy to protect assets against future claims, “Procrastination closes the door on all these strategies,” says Mr. Vanway. “Once you have knowledge that a lawsuit or judgment is pending, it is considered fraud to transfer the assets after a suit has been filed.”

Physicians can earn 4 hours of CME — including 1 ethics hour — by completing the CME activity in *Case Closed*. TMLT policyholders who complete this activity will earn a 3% premium discount (maximum $1,000) applied to their next eligible policy period.

Request a free copy of *Case Closed* by emailing claimbook@tmlt.org. Please specify that you want volume 3 and include your name and mailing address in your email.

Additionally, physicians should understand that the process is very individualized and how complex or simple a plan will be depends on the physician’s individual circumstances. However, when asked if physicians could implement only one asset protection strategy, what should it be, both Mr. Blum and Mr. Vanway said creating a Family Limited Partnership.

Physicians may be hesitant to begin an asset protection plan for a number of reasons including a lack of understanding of the process or a lack of time. “I think there is always a mentality that it will never happen to me. But statistics show that over a physician’s career, the odds are very high that he or she will lose sleep over a potential claim,” says Mr. Blum. “When a claim arises and you have this in place, you know it will not wipe you out.”

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Physician bloggers beware . . . part 2

by Dana Leidig, ABC

Editor’s note: This is the introductory column of a new feature in the Reporter, a regular column on communication issues that affect medical practice and patient safety. Topics will vary. Our goal is to share the latest communication issues we see in medical liability litigation as well as offer risk management approaches to help you avoid the courthouse or improve the defensibility of a lawsuit. Please send suggestions or comments to laura-brockway@tmlt.org.

The November-December 2007 issue of the Reporter, featured an article on physician blogs and discussed areas to consider if you elect to either write your own blog or post responses to someone else’s blog. This article also described an unsettling scenario where a physician involved in a malpractice suit discovered his blog posts were not anonymous, as he had believed.

In an ideal world, blogging has great potential for sharing information among physicians. The reality is far from ideal, however. While it may be informative for physicians to share generic medical observations, experience, and opinions, patient-specific information should not be disclosed in any public forum. Before you contribute to a blog, consider . . . what are the potential costs compared to the potential benefits you may gain?

Jill McLain, senior vice president of claim operations at TMLT, cautions “I cannot emphasize enough to doctors that what they say in a blog can have enormous impact on their careers. You are not anonymous when you are on the Internet. You can be tracked and identified,” she says. “Doctors who may unknowingly cross the line and discuss specific patients and their medical problems, may set themselves up for a medical liability lawsuit.” In addition, any comments you make about yourself or others, may potentially be tracked to you and used against you.

Physician-patient communication is bound by confidentiality rules. Prior to HIPAA and before Internet communication was widely available, physicians discussed patients with other health care professionals by telephone or in person. Their discussions were understood to be confidential communications among professionals. The Internet, however, is completely unregulated. Confidentiality and privacy are not among the advantages offered by the Internet. When confidential patient information is disclosed in a blog, physicians expose themselves and their employers — including hospitals — to medical liability risks, embarrassment, loss of reputation, and costly lawsuits. Even if the patient’s name is not mentioned, if the facts are so similar as to appear to be that patient’s medical information, problems can ensue.

Another downside to contributing to blogs is the undermining of the physician-patient relationship. Imagine the effect on a patient if he identified his own medical case being discussed in an “anonymous” physician blog, complete with embarrassing details of his medical condition and any negative or judgmental comments by his doctor. This physician would most certainly lose a patient and gain a relationship with the Texas Medical Board (TMB) and potentially a medical liability attorney.

In a previous article on blogging, we printed the following advice from American Medical News. It is reated here to emphasize the importance of these guidelines.

• “Be careful about what you say, even if you aren’t using your real name. Never assume that you can’t be identified.”

• Never disclose information or details that identify patients. Tell readers you’re masking identities and consider including a disclaimer to that effect.

• Remember that whatever you write will be permanently online and could be read by potential employers or others.

• Ask your hospital, practice, or other employer about its policy on blogging.

• Post a disclaimer that the views you are expressing are your own.

• Advise readers that you are not offering medical advice. If readers ask for a diagnosis, tell them to consult their physicians.

• Don’t insult another doctor or patient. Don’t type anything you wouldn’t say in person.”

Jay Henderson, an attorney with Cruse, Scott, Henderson & Allen in Houston offers this advice. “One of the best guidelines I have read on this topic was written in response to an article reprinted in the Washington Post. It says ‘Just use the elevator rule. If you wouldn’t say something in an elevator full of people, don’t say it on your blog.’” he says.

According to this article, “‘We’re talking about professions that have legal and ethical obligations regarding privacy that are governed by federal statutes,” said Terry Bonnette, a labor and employment lawyer in Detroit. ‘You should assume when you’re blogging that your anonymity is not absolute.’”

Even sites that claim to offer protection by allowing only physicians to log in pose risk. Some physicians are also plaintiff’s attorneys, and others may be testifying as the plaintiff’s expert in the case you are discussing. The simple act of sharing a log in and password will get anyone into the site.

Medical blogging is a recent development with supporters as well as critics. There is no current law in Texas specifically addressing this issue, but any complaints to the TMF would be addressed under the unprofessional conduct and/or breach of confidentiality sections of the Texas Medical Practice Act. From a liability standpoint, there may be only two safe ways for a physician to approach this activity — obtain patients’ written consent to blog about them, or decide not to blog at all.

Sources

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Failure to diagnose appendicitis

by Barbara Rose and Laura Brockway

Presentation

A 6-year-old girl began vomiting on a Saturday. The child’s mother called her pediatrician, the defendant in this case. The pediatrician prescribed Phenergan suppositories, and told the mother if the girl did not improve over the weekend, to let him know and she would meet them at the clinic or the emergency department (ED).

Physician action

The pediatrician did not hear from the mother again until Monday when he saw the child at the office. The pediatrician indicated that the patient “looks pretty sick, not toxic.” She was mildly dehydrated, and her abdomen was soft and slightly bloated. Bowel sounds were normal with no rebound or guarding. A blood count completed at 9:49 a.m. revealed a normal white blood count of 8.2 with a normal machine differential. Results from a urinalysis were abnormal with positive red and white blood cells, protein, ketones, and nitrate.

The pediatrician’s assessment was gastroenteritis and dehydration. He admitted the patient to a children’s hospital in stable condition. He ordered IV fluids, a CBC, blood cultures and electrolytes, and nothing by mouth except acetaminophen and ibuprofen.

The patient was admitted, and the IV fluids were started at 11:30 a.m. She was complaining of nausea and abdominal pain, but was unable to pinpoint the location. The patient described the pain as throbbing, and the nurse documented that her abdomen was slightly firm and flat and that she had hyperactive bowel sounds. The patient was weak and needed help walking. She had no fever.

Upon admission, the patient’s white blood count was 11.3, but she had 31% bands. Her electrolytes were reported as normal, but fibrin formation was noted by the lab. (The blood culture grew Fusobacterium varium six days later.) No record was found that these results were reported to any physician or nurse.

At 2 p.m., the patient stated that her abdomen hurt, but was better when her mom came in the room. Between 2 and 3:15 p.m., a nurse’s assessment revealed “no distress condition noted at this time.” The next nurse’s notes were timed from 3 to 11 p.m., and the patient’s abdomen was slightly “extended,” tender to touch with bowel sounds present in all quadrants. The patient was weak and had difficulty walking due to abdominal pain.

The patient complained of abdominal pain at 3:15, and was given Tylenol. At 4:15, the nurse noted that Tylenol was “effective” and that the patient was sleeping. At 6 p.m., the nurse documented that she notified the pediatrician that the patient’s abdomen was hard and more “extended” compared to an hour earlier. The pediatrician ordered a surgical consult at 5:45 p.m. He also ordered a CBC, sodium, and potassium.

The record revealed that by 6:15 p.m., a surgical surgeon had seen the patient. His impression was a perforated appendix. He spoke with the patient’s mother, and she agreed to the surgery.

The patient was in the operating room at 6:30 p.m. The postoperative diagnosis was perforated appendix with generalized peritonitis. Following the surgery, the patient had a very complicated hospital stay that lasted more than one month. She was taken back to surgery several times for abscess drainage, necrotizing fasciitis, and skin grafting.

Allegations

A lawsuit was filed against the pediatrician, alleging:

- failure to complete a history and physical exam on the patient when contacted on Saturday;
- failure to hospitalize the patient when she had symptoms of appendicitis and abdominal pain;
- failure to order testing to rule out appendicitis; and
- failure to include appendicitis in the differential diagnosis.

Legal implications

The plaintiff’s expert was critical of the defendant for prescribing Phenergan over the phone without eliciting a more complete history of the patient’s condition. When the patient was seen on Monday, this expert believed that she had an acute abdomen and should have been admitted and a surgical consult requested immediately.

During his deposition, the plaintiff’s expert admitted that diagnosing appendicitis in a young child is difficult, and that there are circumstances in which a pediatrician may miss a diagnosis of appendicitis and not violate the standard of care. He further stated he did not believe the defendant violated the standard of care in failing to diagnose appendicitis. However, the defendant did violate the standard of care by not including appendicitis in the differential diagnosis.

Defense consultants were mostly supportive of the defendant’s actions. One expert pointed out that it was within the standard of care to prescribe Phenergan and to advise the parent to have the child treated in the ED if she did not improve. Based on the defendant’s examination of the child on Monday morning — specifically the lack of rebound, guarding, or significant tenderness — the diagnosis of appendicitis at that time was unlikely.

continued on page 18
Failure to protect patient’s airway
by Barbara Rose and Laura Brockway

Presentation
On October 19, a 35-year-old man was brought to the emergency department (ED) with complaints of dizziness, nausea, vomiting, headaches, blurred vision, and stiffness in his neck. The patient’s medical history included hypertension, alcohol consumption, and smoking one-and-a-half packs of cigarettes per day. He weighed 222 pounds.

Results from a CT scan of the brain were negative, but the patient was noted to have right-sided facial paralysis, numbness, and trouble swallowing. The ED physician recommended the patient be transferred to another facility to be evaluated by a neurologist. After some difficulty finding a hospital to accept the patient, he was transferred to a hospital in a neighboring town.

Physician action
The patient arrived at 3:35 p.m. on October 20. He had impaired speech, facial droop, dysphagia, and wheezing and rhonchi in his lungs. The admitting diagnosis was stroke and bronchitis. He was transferred to the neurology floor for evaluation.

On October 21, a neurologist examined the patient and found him to be alert, awake, and oriented. He noted a blood pressure of 150/90 mm Hg, pulse at 76, and respirations at 20. A cranial nerve exam revealed a central nerve paresis on the right, significant pooling of saliva in the oropharynx, and significant ataxia in the right arm. The neurologist reviewed an MRI that showed the presence of a dorso-lateral pontine infarct on the right and medial and inferior infarcts on the right. He felt the patient needed to be worked up for the stroke, and his orders included placing a feeding tube since the patient had difficulty swallowing due to cranial nerve impairment. He also ordered labs and a carotid-vertebral angiogram for intracranial and extracranial arterial vessels. The angiogram was originally scheduled for October 22; however, the patient declined it because he was concerned about how his swallowing difficulty would affect his ability to remain still on his back for seven or eight hours.

The patient was still having swallowing difficulties on October 23, but he consented to the angiogram. The patient was taken to radiology and given Valium 10 mg IV and Dilaudid 2 mg IV for sedation. The angiogram was performed without incident, and the patient was taken back to his room 45 minutes after the procedure. The post-angiogram orders, written by the radiologist, indicated the maximum head elevation should be 20 degrees, with orders that the patient could be turned to his side only if the arterial puncture leg was kept straight. He also ordered strict bed rest for eight hours.

The angiogram revealed that the right vertebral artery was occluded at the skull base. The distal 4 to 5 cms of the left vertebral artery were severely narrowed 90% to 95% and irregular. The basilar artery and carotids were widely patent. The radiologist felt the narrowing was due to vasculitis or vasculopathy of the distal vertebrae with superimposed acute thrombosis. The neurologist immediately ordered Heparin therapy, which was started about 50 minutes after the order.

Approximately 90 minutes after the angiogram, the patient suffered respiratory arrest. The first three intubation attempts by the code team were unsuccessful. An ED physician was able to intubate the patient who was then transferred to the ICU and placed on a ventilator. A tracheostomy and gastric feeding tube were placed on November 6. The patient remained in the hospital, but showed no improvement neurologically. A DNR order was placed, but then subsequently removed by the patient’s mother. On November 20, the patient was weaned from the respirator and transferred to the skilled nursing unit. He was treated for several bouts of MRSA, but continued in therapy and rehabilitation. The patient’s chronic MRSA infection prevented his admission to nursing home facilities.

Eventually, he was transferred to a nursing home where he remained until the following August. On September 4, the patient was admitted to a local hospital. He had pulled out his tracheostomy tube and refused to be reintubated. He was placed on DNR status. The patient was found unresponsive on September 8 and pronounced dead.

Allegations
A lawsuit was filed against the neurologist alleging that an MRA should have been ordered instead of the angiogram. The plaintiffs further alleged that the patient should have been intubated before the angiogram to ensure that his airway was protected. Lawsuits were also filed against the hospitals where the patient was treated, the nursing home where the patient was eventually transferred, and several other physicians who treated the patient.

Legal implications
The plaintiff’s neurology expert stated that the patient’s stroke could have been diagnosed with an MRA. Obtaining an angiogram was “absolutely unnecessary,” and the delay in waiting to obtain one resulted in additional and significant neurological damage. An MRA would have been faster, less dangerous, and yielded as much information. He further testified that the performance of the angiogram caused neurological damage one hour after the procedure due to aspiration, which caused the anoxia. According to this expert, it was below the standard of care to complete an arteriogram/angiogram without intubating the patient.

A neurologist testifying for the defense stated the defendant acted appropriately and met the standard of care. He advised that an MRA is not as definitive as an angiogram in helping determine what a patient’s underlying problems might be.

A pulmonologist who reviewed this case stated that he saw no evidence to indicate that the patient needed to be intubated before the angiogram because his vital signs were stable. He pointed out that the patient had not had anything by mouth for 12 hours before the angiogram, so it would have taken a lot of secretions into the lungs to continued on page 18
Defense consultants did express concern about why it took the pediatrician so long to obtain a surgical consult once the child was admitted to the hospital. There were several blood counts taken, with the latter one indicating that the white count was 11.3 with 31% bands. While there was no record in the chart that the pediatrician was given that information, consultants questioned why the pediatrician did not more closely follow up on these lab results.

An obstacle for the defense of this case involved a difference of opinion about the Saturday phone conversation between the pediatrician and the patient’s mother. What the mother recalled about the conversation was in direct conflict with what the pediatrician recalled about the conversation. The record did not include complete documentation regarding this conversation.

Disposition
This case was settled on behalf of the pediatrician. Though there was expert support for his care of the patient, it was felt that documentation issues compromised the defense of this case.

Risk management considerations
The medical record should be a complete chronological diary of patient encounters including phone calls during and after hours. To accurately record concerns reported by a patient or parent and the physician’s response and recommendations assures a reliable record of events and leaves no room for conjecture. Physicians are encouraged to develop and implement a system to document phone calls to assure a complete medical record. Options may include a dictated note, direct entry in an electronic medical record, dial back to an answering machine or voice mail at the practice, or a note written on paper and affixed permanently in a paper medical record. When an accurate chronology of events is not included in the record, answers relying on memory long after the fact will likely influence a jury.

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