The responsibility of managing medical records can provoke anxiety in any physician’s office. Medical records are confidential and personal documents, and the rules that govern them are often complex and confusing. Physician practices encounter many unique situations involving medical records. This article will help dispel the common and pervasive myths that surround the retention, release, and management of patient health information.

Myth 1: Physicians must always supply patients with copies of their medical records free of charge.  
Truth: How much a physician can charge for copies of medical records is a commonly asked question. According to the Texas Medical Board (TMB) Rules, “The physician responding to a request for such information shall be entitled to receive a reasonable, cost-based fee for providing the requested information. A reasonable fee shall be a charge of no more than $25 for the first twenty pages and $.50 per page for every copy thereafter.”

The physician is entitled to this fee before releasing the information, unless requested by a licensed Texas health care provider or a physician for purposes of emergency or acute medical care. If a request for information is received other than for emergency or acute medical care, the physician can retain the copies until payment is received. However, if the physician does not receive payment with a proper request—within 10 calendar days after receiving the request (if not for an emergency or acute medical care)—the physician must notify the requesting party in writing of the need for payment, and keep a copy of the letter in the patient’s medical record.

In an emergency situation, physicians should not withhold copies of the medical records until payment is made. If the request involves a claim for disability benefits, the records must be provided free of charge.

Myth 2: Physicians can deny access to a patient’s medical record because of a past due account.  
Truth: Copies of a patient’s medical records cannot be withheld because of outstanding medical bills. According to the TMB, “Medical and/or billing records requested pursuant to a proper request for release may not be withheld from the patient, the patient’s authorized agent, or the patient’s designated recipient for such records based on a past due account for medical care or treatment previously rendered to the patient.”

Myth 3: Physicians must give copies of medical records to family members of deceased patients, no questions asked.  
Truth: Relatives do not always have access to a deceased patient’s medical records. Access to these medical records...
cords is restricted by law to someone who is designated as a “personal representative” of the deceased. A “personal representative” is someone specifically named by the Texas Probate Code as having the authority, when appointed as such by the probate court, to transact business on the part of the estate.

“Rather than comply unquestioningly with a request of this sort, ascertain that you have the written authorization of the right person. Ask for evidence of the person’s legal capacity to obtain the deceased’s records. Often the duly authorized representative will have court-issued papers, called Letters Testamentary or Letters of Administration, reflecting his or her appointment as legal representative on behalf of the deceased.”

Myth 4: Medical records must be kept under “lock and key.”

Truth: While medical records do not need to be locked away, they should be stored in an area that is inaccessible to patients. Medical records should not be stored in hallways, waiting rooms, exam rooms, or in any area where unauthorized individuals could access the records.

Myth 5: A physician is not required to release a minor’s medical record to the minor’s parent if the minor was treated for a condition that does not require parental consent, such as pregnancy.

Truth: Provisions in the Texas Family Code 32.003 allow for a minor to consent to his or her own treatment if the minor:

• is on active duty with armed forces of the United States;
• is 16 years of age or older; resides separately and apart from his or her parents, managing conservator or guardian; and manages his or her own financial affairs, regardless of the source of income;
• consents to the diagnosis and treatment of any infectious, contagious, or communicable disease that is required to be reported;
• is unmarried and pregnant, and consents to hospital, medical or surgical care, other than abortion, related to her pregnancy;
• consents to examination and treatment for chemical addiction, chemical dependency, or any other condition directly related to chemical use; and/or
• consents to counseling or counseling in conjunction with treatment by a physician, psychologist, counselor, or social worker if the treatment and/or counseling is for sexual abuse, physical abuse, suicide prevention, chemical addiction, dependency or abuse.

However, a minor’s ability to consent to treatment may not preclude a parent’s access to any related medical records. Under the Texas Family Code (Section 153.073) the parent of a minor has access at all times to the medical, dental, psychological, or educational records of his or her child. HIPAA does not preclude this access under state law.

Minor patients being treated for conditions that do not require parental consent should be warned that if their parent/guardian demands release of their medical record, the law requires the physician to do so. However, physicians may deny access to the minor’s medical record if they believe that release of the information would be harmful to the physical, mental, or emotional health of the patient.

Myth 6: When a physician receives a request from another physician for a patient’s medical record, staff should just copy and send the entire record.

Truth: Provided that the physician received valid written authorization for disclosure of the health information from the patient or an authorized representative, he or she must send everything contained in the record except any records that relate to mental health care. Mental health care records cannot be released unless the physician receives a specific HIPAA-compliant authorization.

The mental health exception includes any information that the physician may have received from a mental health professional—psychiatrist, psychologist, or licensed professional counselor—related to treatment for a “mental or emotional condition or disorder, including alcoholism and drug addiction.”

“If you are not a mental health care provider, but receive records, correspondence, etc. from the mental health providers of your patient, divide these records from the remainder of your patient care records (e.g., with a divider) so they will not inadvertently be copied and forwarded with the other records when complying with a record request.”

Myth 7: Privacy laws do not allow physicians to re-disclose copies of medical records that they have received from other health care providers.

Truth: According to the Texas Medical Practice Act, if the physician receives a valid medical records request, that physician must furnish copies or a summary of his or her own medical records, and copies of records received from other physicians or health care professionals involved in the care or treatment of the patient. The re-disclosure of information must be “consistent with the authorized purpose for which the information was first obtained.”

“If your office has acquired records from another physician or health care provider to supplement your medical care of the patient, then you may re-disclose the information to another physician or health care provider for the same reason.”

Precautions already outlined in Myth 6 about mental health information still pertain. Mental health records cannot be released unless the physician receives a specific HIPAA-compliant authorization.

Myth 8: Physicians must keep medical records for all patients for 10 years.

Truth: According to TMB rules, all medical records for adult patients must be kept for at least seven years from the date of the last encounter. Records for minor patients must be kept for at least seven years from the date of the last encounter or until the child turns 21, whichever is longer. These same guidelines apply to the retention of medical records for deceased patients.
Myth 9: Physicians can discard the medical records that they are no longer required to keep by throwing them in the trash.

Truth: According to the American Health Information Management Association (AHIMA), medical records should be destroyed so there is no possibility of reconstruction of information. Appropriate methods include burning or shredding. The AHIMA also recommends that physicians:

• Develop methods to destroy computerized data permanently and irreversibly. (Pulverization is an appropriate means.)
• Reassess destruction methods annually.
• Document the destruction as follows:
  • Date of destruction,
  • Method of destruction,
  • Description of disposed series, and
  • Inclusive dates covered.”

Myth 10: A physician who is closing a practice and will no longer be treating patients can give his or her patients the original copies of their medical records.

Truth: Patients should never be given original copies of medical records. If a lawsuit occurs at any time in the future, the physician will not have a copy of the medical record available to defend the case.

The TMB has specific rules that physicians must follow when closing their practices, including notices to patients providing an opportunity to obtain copies of medical records. These rules also include information on the transfer of ownership of medical records. Please refer to TMB rules sections 165.1 to 165.5. 4, 6

Myth 11: HIPAA rules do not allow physicians to fax copies of medical records.

Truth: Copies of medical records can be faxed. However, the law “requires adoption and implementation of reasonable safeguards for security of all health information. This includes safeguards for the transmission of health information via computer, facsimile and other modes of communication. Procedures for utilizing the fax machine should make every effort to prevent the release of confidential medical records and reports to unauthorized persons. Medical information should only be faxed for urgent or emergent care.” 5

Risk management tips for faxing medical records include the following:

• develop policies and procedures for sending and receiving faxed information;
• print a confirmation that the fax was received;
• tell the individual who will be receiving the fax when the records will be faxed so the person can secure the information;
• do not fax sensitive information such as HIV, mental health, or alcohol/drug abuse records unless necessary for emergency care;
• use a fax cover sheet that indicates the need to maintain confidentiality; and
• install your fax machine in an area away from patient traffic. 5

Myth 12: When a patient requests copies of his or her medical records, the physician has 30 days from the date of request to supply the copies.

Truth: According to TMB rules, “The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician within 15 business days after the date of receipt of the request and reasonable fees for furnishing the information.” Please see Myth 2 for information on how much a physician can charge for copies of medical records.

Myth 13: Physicians are allowed to “clarify” past entries in medical records after an unexpected outcome or notice of claim.

Truth: The TMB documentation rules do not allow physicians to alter medical records unless they clearly indicate that this is what they are doing. “Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.” 4

Additionally, altering a medical record after an unexpected outcome can be detrimental. The changes may look suspicious or it may appear that the physician is “beautifying” the medical record to cover up damaging information. “Addendums to the medical record may be allowed if done in a timely manner and clearly identified. Include the date and time, a reference to the date and time of the actual encounter, reason for the addendum, the added information, and author’s signature.” 7

Myth 14: Physicians do not need to initial or sign entries in medical records.

Truth: TMB rules require that, “each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous, and legible.” This includes the “date and legible identity” of the physician or other observer who made the entry. 4

Signing an entry in the medical record is necessary to reflect the identity of each person and to clearly reveal what is done by those who are allowed to document information in the record.

Myth 15: Using an electronic medical record (EMR) system means that medical records cannot be stolen or lost.

Truth: EMRs are not impervious to theft, tampering, or loss. The U.S. Department of Health and Human Services (HHS) offers the following suggestions for EMR security:

1. Use a log-in password that is not easily guessed. Make it at least 8 characters long and composed of upper- and lower-case letters, numbers, and symbols such as ‘#’ and ‘&.’
2. Immediately change the default password on new laptops.
3. Never set the log-in dialog box to remember your password.
4. Use a password-protected screen saver that comes on after several minutes of inactivity.
5. Keep antivirus and spyware programs up-to-date, and use them.
6. Keep operating-system and application software patched with the latest security fixes.
7. Back up your data to a location other than the laptop hard drive. Keep CDs and floppy disks separate from your laptop.
8. Disable the infrared port. Laptops can read other laptops’ data from across a conference table. Cover the infrared port with black electrical tape.”  

Additionally, it is recommended that users should never share passwords and patient encounter notes should be locked after the entry is complete.  

Special care should be taken with laptops. In February 2008, a laptop was stolen from a researcher at the National Institutes of Health. The laptop contained medical information on more than 3,000 people who were participating in a study. American Medical News called the incident “an example of why physicians and other health care professionals must remain vigilant about the security of patient data.”  

HHS offers the following suggestions on how to prevent the loss or theft of a laptop that contains medical information.

1. Do not leave your laptop unattended in an unsecured environment — even for a few seconds. When considering precautions, remember that thieves look for easy targets.
2. In the office, store the laptop in a locked drawer and lock your door.
3. Consider attaching a security cable, and wrap the cable around an unmovable, unbreakable object.
4. Most laptops come with a socket that can be attached to a security cable. If yours doesn’t, your cable may come with an adhesive-backed attachment that will fasten the cable to the laptop. On the cable itself, a cylinder lock is stronger than a combination lock. While cable cutters could easily slice through the wire cables, from a thief’s perspective, they are conspicuous.
5. Instead of using a laptop carrying case—especially one with the manufacturer’s name on the outside—consider putting the laptop in a padded case, then in a backpack, briefcase, or other ordinary-looking holder.
6. Never leave a laptop visible in a vehicle. Cover it with something, such as a blanket, or put it in the trunk. Do not leave laptops in vehicles for extended periods. Winter lows can freeze and split LCD screens. Summer temperatures can melt components.
7. Think about additional security devices, such as laptop alarms and hard-drive locks. Remember that while they work, they add bulk and cost, and delay your use of the computer. Some machines come with fingerprint readers.”  

To protect against the loss of data in an EMR system, ensure that data is being backed up reliably. Back-ups can and do fail, and this could result in the loss of all patient records.

“Creating a back-up data set is only the first step. The back-up record must be tested regularly to ensure that all appropriate data are being copied, and that data restoration is possible. Testing should occur for all back-up types, including in-house creation on a removable hard drive or for processes that send the information over the Internet for offsite storage. Even if an EMR vendor is providing offsite back up, physicians are advised to confirm that the data is created appropriately.”  

Sources

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Physician-patient collaboration in decision making  

by Dana Leidig, ABC

Physicians and patients sharing in patient health care  
decisions has been a developing trend over the past 20  
years. This trend has led “a number of prominent medical  
journals to publish articles heralding a ‘paradigm shift’ in  
which the concept of shared decision making is said to  
be replacing the old notion that ‘doctor knows best.’”  
1

It is not surprising that some patients may desire a  
greater voice in deciding what happens to them after a  
medical diagnosis has been delivered. Ours is a world where  
patients have been encouraged to take a more active role  
in their own health care and where they can access a wide  
range of health information from a number of credible  
Sources on the Internet. On the Web, they can research their  
symptoms, uncover the name of a potential condition or  
disease, and read about the pros and cons of treatments for  
the condition. Some patients may arrive for their doctor’s  
appointment armed with their own medical diagnosis and  
an idea of what medical treatment might be best.

For better or worse, “during the past several decades,  
the patient-physician relationship has evolved from a paternalistic  
model to views in which medical decision making is  
emphasized as a joint negotiation and partnered decision  
between patient and physician.”  
2 This type of partnership requires mutual trust and the ability of both partners to clearly communicate with one another.

Those patients and physicians who want to participate in a shared decision making process must recognize the unique role each assumes in this partnership. These “partners” work together to achieve common goals.  
3 and they must each respect the other’s point of view. While the physician is the clinical authority, the patient contributes his or her past experience with illness, preferences, and attitudes toward risk.  
4

The physician’s role requires the introduction of information to the patient, explanation of the medical diagnosis and prognosis, and treatment options. The patient’s role requires that he or she have time to digest this information, ask questions, conduct personal research, and perhaps discuss the information with friends or family.

In shared decision making, the physician and patient make the decision together after they have evaluated available information and weighed the risks versus the benefits of a procedure or treatment. “Shared decision making in its fullest sense occurs only when real choice exists and the physician involves the patient in the decision.”  
3

How does shared decision making differ from informed consent? These “two means, one developed for the most part in ethics (shared decision making) and the other developed primarily in law (informed consent), could both operate to create the same collaborative environment and serve the same goal.”  
3 The end result of both processes allows the patient to assert some control over his or her medical care.

However, informed consent is tied to the relative risk of the procedures being considered. Higher risk procedures, such as surgeries, require that physicians discuss the risks and benefits with the patient. The patient can then decide whether to accept or refuse this treatment. In cases where the medical decision involved greater risk, the likelihood of disagreement between doctor and patient increased.  
2, 3

When there is low risk to the procedure being considered, such as prescribing a corticosteroid cream to treat contact dermatitis on a patient’s arm, the physician can explain the diagnosis at the office visit and patient consent is assumed if the patient fills the prescription and uses the medicine. “Informed consent . . . is always expressed, meaning that the patient explicitly authorizes the intervention, but simple consent may be indicated implicitly, for example, by accepting and filling a prescription...”  
3

An Iowa survey reported, “Patients with similar attitudes as their physicians toward patient/doctor roles were more satisfied with care and more likely to follow treatment." However, when a patient-centered physician and a patient who wanted a paternalistic physician tried to make decisions together, the patient was often dissatisfied with care and did not follow the treatment plan.  
6

Not all patients and physicians desire to approach health care decision making as a shared activity. Fifty-two percent of respondents to a recent survey indicated that they “preferred to leave the final decision up to their doctor.” However, this same survey also showed that “the vast majority of patients want to be offered choices,” even those who preferred that their doctor make the final decision.  
5

Sources


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Treating your patient’s pain

legal, regulatory requirements for the management of chronic pain

Course author
Barbara Rose is a senior risk management representative at TMLT.

Disclosure
Barbara Rose 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.

Release/review date
This activity is released on August 4, 2008 and expires on August 4, 2010. Please note this CME activity does not meet TMLT’s discount criteria. Physicians completing this CME activity will not receive a premium discount.
Objectives

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

1. discuss statistics about chronic pain and its associated costs;
2. recognize the impact of state and federal laws in caring for patients with pain;
3. identify chapters of the TMB and Medical Practice Act that govern the physician in pain management; and
4. access resources and tools available to physicians for guidance in pain management.

Introduction

Pain—we all experience it at some time in our lives. None of us welcomes it. Pain is an unwelcome intruder but functions as the body’s way of telling us something is wrong. John J. Bonica, the father of modern pain management, defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.” Pain is the body’s way of telling us something is lacking homeostasis, a measure of a person’s well-being.

“Pain is one of the most common reasons that patients seek medical care, yet it is often inadequately treated. Untreated, the pain accompanying illness slows recovery, adds financial burdens to the health care system, and severely impairs quality of life.” Listening to your patient is at the heart of the physician-patient relationship. Put yourself in the patient’s shoes and consider how you would want to be treated if you had unresolved pain.

This article will present recent statistics on the treatment of pain, review rules and regulations that influence the management of patients with chronic pain, and discuss the challenges in the care of patients with chronic pain.

The painful facts

Pain is a national health care crisis. The Power Over Pain Campaign, a project of the American Pain Foundation, has these statements on its web site.

- “Pain is the number one reason people seek medical care. More than 70 million Americans suffer from chronic pain, and another 25 million suffer from acute pain as a result of injuries or surgery.”
- Individuals in pain face “significant barriers that prevent proper assessment, diagnosis, treatment and management of their pain. Adequate pain care is necessary for improving and maintaining quality of life for people with pain and their families.”
- Individuals in pain “have a right to timely, appropriate pain care.”

A recent survey sponsored by the National Pain Foundation, asked adults in the U.S. to measure the incidence and types of pain they experienced during the last 12 months. Key findings indicated that 42% of those surveyed were experiencing some form of pain on the day of the survey; 72% experienced pain in the last 12 months; and 27% experienced acute pain. The survey revealed that many adults with pain are reluctant to see a physician or take prescription pain medications as 57% did not see a health care professional; 35% saw a physician but with a delay; and 8% went to a physician right away.

At the 2008 American Academy of Pain Medicine annual meeting, Dr. Michael Cousins, a professor and department head of anesthesia and pain management at the University of Sydney, discussed the “Decade of Pain.” He stated that pain is a disease in its own right, acknowledging the “concept of pain as a disease entity leads us toward new specific treatments aimed at physical, psychological, and environmental components of the disease, and take into account the possibility of a genetic predisposition to experience pain.” In his second point, Dr. Cousins stated that “the medical community has now recognized that additional specialty training in pain management is absolutely necessary. There are too few true pain medicine specialists being trained, and many patients have limited or no access to effective pain treatment.”

Patients who think their chronic pain is discounted by physicians often overuse emergency departments. His final point emphasized that “pain management needs to truly become a fundamental human right. To achieve this goal, we need parallel initiatives in medicine, law, ethics, and politics.”

Pain medication use on the rise

The cost of chronic pain is staggering. “Pain has emerged as a devastating public health problem. According to the American Chronic Pain Association, pain is the number one cause of adult disability in the U.S. Estimates for the economic impact of pain vary. “A 2003 study published in the Journal of the American Medical Association put the cost at $61.2 billion per year.” This figure only represented the losses by U.S. businesses due to lost employee productivity and only included arthritis, back pain, headache, and other musculoskeletal pain.

The Centers for Disease Control and Prevention’s 2004 annual report card on health in the U.S. included the following about pain:

- “more than one in four American adults reported low back pain in the last 3 months;
- 15% of adults reported migraine or severe headache;
- about one-third of adults 18 and older and half of adults 65 and older reported joint pain, aches, or stiffness with the knee as the most common site;
- use of narcotic pain medication has increased; from 1988 to 1994, 3.2% of Americans took narcotics for pain; that percentage rose to 4.2% in 1999-2002.”

Albert Ray, MD, chairman of the National Pain Foundation, writes that “confusion and misinformation surrounding the use of opioids—commonly known as narcotics—has contributed to the already significant problem of under-treating pain in the more than 70 million Americans who live with it daily.” Federal drug prescription data concluded that retail sales of five commonly prescribed pain medications have almost doubled over the last eight years. Dr. Ray acknowledges the significance of the report, but explains that it did not tell the full story. He attributes the increase in pain medication usage to several factors, including:

1. “a trend to reversing the under-treatment of pain,
2. more research and improved scientific understanding of pain as a disease,
3. increased awareness and education about how to properly treat pain, and
4. advances in pharmaceuticals.”

More physicians now “understand that pain must be treated to improve function and quality of life in those who live with chronic pain conditions.”

“Overlooked and underreported is the fact that this class of drugs (opioids), when
used properly and under medical supervision, has kept millions of Americans more functional in the face of pain-producing illnesses and accidents.” 9

“If the public is to be properly informed about health issues and advances in medicine, it is incumbent upon the press to present that information in an unbiased way rather than sensationalizing stories.” 9

Recent research

In his article, Dr. Ray acknowledges that “Pain research over the last 20 years has now shown that undertreated pain can lead to pathological changes in the nerves (the peripheral nervous system) and the spinal cord and brain, which make up the central nervous system. These changes result in pain becoming a chronic disease, with consequences such as:

- long-term pain,
- increased levels of pain and disability,
- decreased ability to concentrate and difficulty with memory,
- significant levels of depression and anxiety,
- inability to function at home or work,
- poor sleep, and
- an increase in other problems such as irritable bowel syndrome, headaches, chronic fatigue syndrome, fibromyalgia, all of which tend to become chronic problems.” 8

Today’s physicians are “aware of the importance of treating pain properly and aggressively to reduce or prevent these negative consequences on a person’s life.” 8

Dr. Ray further states that “research has shown that most patients, if they use their opioid medications properly, will never become addicted to them. Most individuals who have problems with medication addiction have a genetic propensity to become addicted, already had an addictive disorder, or both.” 8

Legal and regulatory aspects

Recognizing the perils of undertreatment and overtreatment of patients with pain, a review of the rules, regulations, and guidelines related to pain management is relevant.

“Unlike other medications, the prescription and use of opioids and other controlled substances have wider societal implications beyond the usual ones that exist between individual health care providers and their patients. Opioids prescribed for pain relief for an individual patient may be diverted and abused by other persons. Because of this issue, many parties such as the Drug Enforcement Agency (DEA), state licensing boards, state law enforcement agencies, and health care benefit plans are involved in the regulation and oversight of opioid use. Health care practitioners who prescribe opioids find themselves having to meet the requirements of these parties in addition to addressing the clinical needs of their patients.” 10

In this regulatory climate “it is not surprising that the prescription of opioids for intractable pain remains a controversial and circumspect practice among the current generation of physicians.” 10

“Regulations relating to the treatment of pain are subsets of those governing the overall practice of medicine. Therefore, regulations that set the standard for excellence in the practice of all medical disciplines apply to the pain practitioner.” 10

“The practice of pain medicine has an added dimension because opioids, which are indispensable for the treatment of moderate to severe pain, are surrounded by myths, strong emotions, and misinformation that serve as societal barriers to their proper medical use.” 12

Federal and state law

The government “authorizes medical use of medications such as opioids through two distinct categories of laws: 1) controlled substance acts (CSAs) that regulate physiologically active chemicals, and 2) health care practice acts (HPAs) that set standards of medical practice.” 11

When registering for a number with the DEA, the physician is requesting permission from the federal government to prescribe Schedule 2, 3, 4, and 5 substances. “From Schedule 2 (most potential) to Schedule 5 (least potential), listed drugs and chemicals have descending abuse liability and risk of physical and psychologic dependence.” 11

In Texas, policies regarding pain treatment or the use of controlled substances include medical board regulations and policy statements, and an Intractable Pain Treatment Act (IPTA). 11

The Medical Practice Act (MPA)

While the Texas Medical Board (TMB) is the state agency “charged with protecting the public from unqualified practitioners of medicine and maintaining excellence in the practice of medicine,” 12 the regulations are contained in the Medical Practice Act (MPA), a law created by the Texas Legislature. Specific standards of medical care are not part of the MPA. The Texas MPA is found in Texas Administrative Code, Title 22, Part 9, Chapters 161 to 200 of the Texas Occupational Code and is available at www.tmb.state.tx.us. Of particular relevance for the physician treating patients with pain is Chapter 169, Authority of Physicians to Supply Drugs and Chapter 170, Pain Management. 14

Chapter 170 includes the rules, definitions, and guidelines applicable to pain management. The TMB will use these guidelines to assess a physician’s treatment of pain:

1. evaluation of the patient;
2. treatment plan for chronic pain;
3. informed consent;
4. agreement for treatment of chronic pain;
5. periodic review of the treatment of chronic pain;
6. consultation and referral; and
7. medical records. 14

The chapter in its entirety may be found at www.tmb.state.tx.us. Key guidelines are summarized below.

“A physician is responsible for obtaining a medical history and a physical examination that includes a problem-focused exam specific to the chief presenting complaint of the patient.” (Rule 170.3(a)(1)(A))

“The medical record shall document the medical history and physical examination. In the case of chronic pain, the medical record should document:

(i) the nature and intensity of the pain,
(ii) current and past treatments for pain,
(iii) underlying or coexisting diseases and conditions,
(iv) the effect of the pain on physical and psychological function,
(v) any history and potential for substance abuse, and
(vi) the presence of one or more recognized medical indications for the use of a dangerous or scheduled drug.” (Rule 170.3(a)(1)(B))

“The physician is responsible for a written treatment plan that is documented in the medical records. The medical record should include:

(A) How the medication relates to the chief presenting complaint of chronic pain;
(B) dosage and frequency of any drugs prescribed,
(C) further testing and diagnostic evaluations to be ordered,
(D) other treatments that are planned or considered,
(E) periodic reviews planned, and
(F) objectives that will be used to determine treatment success, such as pain
Informed consent — “It is the physician’s responsibility to discuss the risks and benefits of the use of controlled substances for the treatment of chronic pain with the patient, persons designated by the patient or with the patient’s surrogate or guardian if the patient is without medical decision-making capacity. This discussion should be documented by either a written signed document maintained in the records or a contemporaneous notation included in the medical records.” (Rule 170.3(a)(3))

Agreement for treatment of chronic pain — “A proper patient-physician relationship for treatment of chronic pain requires the physician to establish and inform the patient of the physician’s expectations that are necessary for patient compliance. If the treatment plan includes extended drug therapy, the physician should consider the use of a written pain management agreement between the physician and the patient outlining patient responsibilities, including the following provisions:

(A) the physician may require laboratory tests for drug levels upon request;
(B) the physician may limit the number and frequency of prescription refills;
(C) only one physician will prescribe dangerous and scheduled drugs;
(D) only one pharmacy will be used for prescriptions, and
(E) reasons for which drug therapy may be discontinued (e.g. violation of agreement).” (Rule 170.3(a)(4))

Periodic patient assessment and review of the treatment plan is expected and “if progress is unsatisfactory the physician should reassess the current treatment plan and consider the use of other therapeutic modalities.” (Rule 170.3(1)(5)(iv))

Consultation and referral — “The physician should refer a patient with chronic pain for further evaluation and treatment as necessary. Patients who are at-risk for abuse or addiction require special attention. Patients with chronic pain and histories of substance abuse or with co-morbid psychiatric disorders require even more care. A consult with or referral to an expert in the management of such patients should be considered in their treatment.” (Rule 170.3(a)(6))

Medical records — “The medical records shall document the physician’s rationale for the treatment plan and the prescription of drugs for the chief complaint of chronic pain and show that the physician has followed these guidelines.” (Rule 170.3(a)(7))

For clarification, Rule 170.1 titled Purpose states that “the intent of these guidelines is not to impose regulatory burdens on the practice of medicine. Rather, these guidelines are intended to set forth those items expected to be done by any reasonable physician involved in the treatment of pain. The use of the word ‘shall’ in these guidelines is used to identify those items a physician is required to perform in all such cases. The word ‘should’ and the phrase ‘it is the responsibility of the physician’ in these guidelines are used to identify those actions that a prudent physician will either do and document in the treatment of pain or be able to provide a thoughtful explanation as to why the physician did not do so.” (Rule 170.1(9)) It is advisable for physicians to be familiar with Rule 170, parts 1, 2 and 3.

Intractable Pain Treatment Act (IPTA)

In 1989 “Texas became the first state to pass an IPTA, restricting opioid use but providing immunity to physicians compliant with the law. Texas defines intractable pain as a state of pain in which ‘the cause of pain cannot be removed or otherwise treated and in the generally accepted course of medical practice no relief or cure of the cause of pain is possible or has been found after reasonable effort.’”

“Physicians in Texas should verify that their patients with chronic pain on opioids fulfill the burden of this definition, and document the patient’s condition as ‘intractable pain.’” The IPTA may be found in the Texas Civil Statutes, Title 71, Health Public, Article 4495c.

National guidelines and standards

The Federation of State Medical Boards has developed and adopted a Model Policy for Use of Controlled Substances for the Treatment of Pain that state medical boards can use to evaluate a physician’s treatment of a patient’s pain. The goal of the policy is to improve the quality and access to appropriate pain care. The guidelines, among other things, specify that a physician should:

- conduct and document a physical examination and thorough medical history, including any history of drug use and the effect of pain on the patient’s function;
- develop a written treatment plan that includes objectives that will be used to determine treatment success;
- obtain informed consent and consider asking patients with a high risk for medication abuse to sign a medication agreement;
- conduct periodic reviews during the patient’s course of treatment;
- be willing to refer the patient to specialists to achieve treatment objectives;
- keep accurate and complete medical records; and
- comply with controlled substance laws and regulations.

In 2000, the American Pain Society and the Joint Commission agreed on new standards for pain assessment and management in all accredited facilities. The standards apply to hospitals, ambulatory care facilities, behavioral health care facilities, health care networks, home care, long-term care organizations, long-term care pharmacies, and managed behavioral health care organizations. The standards “emphasize a collaborative and interdisciplinary approach, individualized pain control plans, assessment and frequent reassessment of pain, use of pharmacologic and nonpharmacologic strategies, and establishment of a formalized approach.”

Briefly, the standards “require that health care organizations comply with the following:

- Recognize the right of patients to appropriate assessment and management of pain;
- Screen for the existence and assess the nature and intensity of pain in all patients;
- Record the results of the assessment in a way that facilitates regular reassessment and follow up;
- Determine and ensure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff;
- Establish policies and procedures that support the appropriate prescription or ordering of effective pain medications;
- Educate patients and their families about effective pain management;
- Address patient needs for symptom management in the discharge planning process and;
- Maintain a pain control performance improvement plan.”

To provide further guidance to health care professionals, three national medical organizations—the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine—jointly prepared and adopted
Pain management resources from the American Academy of Pain Medicine web site

American Academy of Physical Medicine & Rehabilitation — the national medical society representing more than 6,200 physicians who are specialists in physical medicine and rehabilitation. Available at http://www.aapmr.org/

American Chronic Pain Association — is a nonprofit organization with more than 800 chapters worldwide. Their purpose is to provide a support system for those suffering with chronic pain through education and self-help group activities. Available at http://www.theacpa.org/

American Pain Foundation — is a nonprofit resource and patient advocacy organization serving people with pain. Their mission is to improve the quality of life of people with pain by providing information for patients, raising public awareness and understanding of pain, and advocating against barriers to effective treatment. Available at http://www.painfoundation.org/

American Pain Society — is a multidisciplinary organization of basic and clinical scientists, practicing clinicians, policy analysts, and others. The mission of APS is to advance pain-related research, education, treatment and professional practice. Available at http://www.amspain.org/

American Pain Society’s Decade of Pain Control and Research — provides information about treatment, the pain care bill of rights, finding support, voices of people in pain, links, as well as well as clinical and research resources. Available at http://www.amspain.org/decadeofpain/

Cochrane Collaboration — an international organization that aims to help people make well-informed decisions about health care by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care interventions. Available at http://www.cochrane.org/

National Headache Foundation — is a non-profit organization dedicated to educating headache sufferers and health care professionals about headache causes and treatments. Available at http://www.headaches.org/

PainEDU.org — an online resource for clinically relevant information about pain assessment and management that offers medical professionals the opportunity to stay current with news and literature in the pain management field. Available at http://www.painedu.org/index.asp

National Pain Foundation — an online education and support community for patients and their families. Available at http://www.nationalpainfoundation.org/

Pain.com — is a resource for health care professionals and consumers who have an interest in pain and its management. This site is sponsored by the Dannemiller Memorial Educational Foundation.

Pain and Policy Studies Group — facilitates public access to information about pain relief and public policy. The Pain and Policy Studies Group, at the University of Wisconsin, addresses both domestic and international policy issues and is a World Health Organization Collaborating Center for Policy and Communications in Cancer Care. Available at http://www.painpolicy.wisc.edu/


A multidisciplinary approach

Treating pain may involve a variety of health care professionals along with “an arsenal of treatments and approaches. Opioids can be an effective weapon against pain; however, the over-the-top fear mongering about addictive pain medicines often keeps patients from seeking help and prevents primary care medical providers from referring people with chronic pain to pain specialists.” Writing on the National Pain Foundation web site, Dr. Ray described some of the medications, procedures, and techniques to treat pain. They include:

- “non-opioid pain medicines such as anti-depressants, anti-convulsants, and non-steroidal anti-inflammatories,”
- neuromodulation methodologies, including electrical stimulators for the nervous system and implanted medication pumps which deliver preset amounts of medications directly to the nervous system,
- physical therapy, massage, ice or heat,
- acupuncture, and
- behavioral and psychological treatments that directly alter the way a person’s brain processes pain information.”

An article published in Missouri Medicine, discussed assessment steps in pain management and described the “Four A’s” of pain medicine. The physician must regularly “assess the patient’s level of analgesia, ability to perform activities of daily living, the presence of adverse effects, and the presence of any aberrant behavior that could include addiction, abuse, or diversion.” These authors concluded that “pain management specialists in collaboration with members of other disciplines, including primary care physicians, can work with patients with chronic pain to meet their goals and expectations and thus ensure the successful management of their chronic pain.”

Resources and tools

Various professional and patient organizations provide information and practice tools for physicians. The International Association for the Study of Pain (www.iasp-pain.org), the American Pain Society
Risk management considerations

Balancing the scales in the management of risk relevant to the treatment of pain may feel like skating on thin ice and influence a physician’s treatment choices. Under prescribe and you may be accused of abuse and of allowing your patient to suffer needlessly. Prescribe aggressively to control pain and it may be alleged that you contributed to a patient’s drug addiction. These fears interfere with a physician’s ability to focus on the medicine. “Physicians must seek a middle ground between the unfettered prescription of opiates and the fear that prevents them from relieving pain.” 22

• With so much of today’s health care occurring in the ambulatory setting, evaluate your pain assessment process. View it as the fifth vital sign. Consider implementing a pain assessment chart as part of your patient history form. Add practical questions such as “How often does pain interfere with daily activities?” and “How has your pain affected your relationships?” 11

• In addressing the needs of a patient with chronic pain, have established protocols in your practice. Become knowledgeable about federal and state regulations and guidelines for prescribing controlled substances. Keep abreast of the most current schedules of medications and access the DEA’s website at www.usdoj.gov/dea.

• Documentation influences how a jury or board reviewer perceives a physician and his or her practice. Adopt and implement the use of comprehensive forms. “Understanding your legal/regulatory obligations related to prescribing controlled substances to treat pain.” 23 Doing this should lay the foundation for a physician to focus on quality medical care and preserve your patients’ access to controlled substances. 11

Document comprehensively at the time of care with the assurance that the reasons used to determine a treatment plan are evident based on “an adequate history, physical examination, pertinent diagnostic studies, and consultations.” 12

• In addition to documentation of an informed consent discussion and the patient’s compliance agreement, physicians may wish to implement a signed consent form and controlled substance agreement. (Please see a sample controlled substance agreement on page 13)

• Identify and implement protocols for the successful collaboration with pharmacists in the management of pain. In the Journal of Opioid Management, Strickland et al wrote “pharmacist-physician collaboration in pain management practice is challenging and rewarding, but it sometimes requires a level of effort and accommodation that may not seem natural to health care providers whose practices have evolved in traditional settings.” The article further states “through physician-pharmacist collaboration, pain management outcomes can be optimized and risk can be managed.” 24 This cooperation between physician and pharmacist benefits the patient and “provides protection for those who are meeting the patient’s needs.” 24

• “The most important message that physicians must communicate to persons with chronic pain is that, currently, no medication exists that will take away more than 30% of the pain they experience. Chronic pain is a chronic disease and, like diabetes or hypertension, requires chronic concessions and lifestyle modifications. Familiarity with federal and state controlled substance legislation and state health care provider and pain treatment acts is a mundane but essential educational endeavor for all physicians prescribing opioids. If physicians educate their patients with chronic pain about the limited efficacy of the medications, patients’ expectations for drug treatment can be more realistic.” 11

Conclusion

Legal and regulatory actions influence the management of pain. This conflict emerges largely as a result of society attempting to simultaneously eliminate undertreatment of pain and prescription drug abuse and diversion. 10 “The policies and actions of the DEA, for better or worse, set the tone and drive physicians’ perceptions about the legal risk associated with prescribing controlled substances.” 10

“While the law may require the documentation of processes, medicine requires, and safe prescribing mandates, good solid communication with patients about the issues surrounding the use of controlled substances to treat pain and the responsibilities of both parties—the physician and the patient.” 25

Whether your area of medicine is that of a primary care physician, a surgeon, a subspecialist or physician specifically dedicated to pain management, the assessment and treatment of pain presents myriad challenges. The patient’s age, ethnicity, spiritual/philosophical beliefs, familial and social environment will influence one’s response to pain. “Pain is multi-dimensional and everyone has a different pain threshold.” 25

Pain management may be one of the most challenging aspects of medicine. As a physician, assess your knowledge and competence level with the treatment of pain. Those who specialize in pain management generally believe that physicians are not learning enough about pain in medical school and residency. If honest introspection and self-assessment reveal a lack of knowledge to competently manage this complex medical, social and even legal issue, take action. Become familiar with the laws, regulations, and guidelines that influence prescribing and caring for patients with pain. Learn pain control techniques. Assess patients for pain. Be aware of biases in the treatment of pain. Be open to complimentary therapies and recognize when to refer.

References


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Editor’s note: A companion article on prescription drug diversion will be featured in the September-October 2008 issue of the Reporter.

Physicians can sign up to receive “dear doctor” letters by email

Beginning in July 2008, U.S. physicians will be able to receive drug safety alerts from the Food and Drug Administration (FDA) and drug manufacturers via email. The online service, called the Health Care Notification Network (HCNN), is free to physicians and will be used only to send patient safety alerts. Currently, these alerts—also known as “Dear Doctor letters”—are sent to physicians on paper via U.S. mail. 1

According to the HCNN, more than 100,000 physicians have already signed up to receive the alerts. 1

The HCNN is designed to improve the speed and efficacy of the delivery of patient safety alerts to physicians. The alerts sent by the HCNN will be targeted in the same manner as are the alerts currently sent on paper via U.S. mail. Most alerts are targeted to specific specialties and/or those who prescribe a particular medication. 1

The network is being promoted by the American Medical Association, physician specialty groups, and drug and device manufacturers. A nonprofit board, the iHealth Alliance, governs the service and will ensure that email addresses of registered physicians are used exclusively for safety alerts and not for advertising. Medem will operate the network. 2

According to the HCNN web site, physicians who are signed up to receive the alerts, but who do not open them will receive a paper-based alert typically sent via U.S. mail. Physicians not enrolled in the HCNN will receive the alert through the current paper-based process, typically sent via U.S. mail. Physicians can also log in to the HCNN and view saved or deleted alerts sent during the preceding 12 months. Alerts can also be automatically sent to other designated office staff. 2

Physicians can sign up for the service by visiting http://www.hcnn.net/default.aspx.

Sources
Patient responsibility agreement for controlled substance prescriptions

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen or if I “run out early,” I understand that it will not be replaced.

2. Refills of controlled substance medications:
   a. Will be made only during regular office hours Monday through Friday, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends, or during holidays. No refills by phone.
   b. Will not be made if I “run out early,” or “lose a prescription,” or “spill or misplace my medication.” I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   c. Will not be made as an “emergency,” such as on Friday afternoon because I suddenly realize I will “run out tomorrow.” I will call at least 24 hours ahead if I need assistance with a refill. My prescription must be refilled in person in the office.

3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.

4. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of nonprescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.

6. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

7. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.

8. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

   Name: _______________________________ Phone: _______________________________

I have been fully informed by Dr. _______________________________ and his/her staff regarding psychological dependence (addiction) of controlled substance medications, which I understand, is rare. I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect, and there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I must do so slowly while under medical supervision or I may have withdrawal symptoms.

I have read this contract and the same has been explained to me by Dr. _______________________________. In addition, I fully understand the consequences of violating this agreement.

Patient Signature _____________________________ Witness Signature _______________________________ Date __________________

[All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted–with the advice of the organization’s attorney–to meet state, local, individual organizations and department needs or requirements. They are distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services.]
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. Pain is the most prevalent reason individuals seek medical care.
   ○ True
   ○ False

2. A survey sponsored by the National Pain Foundation found that
   ○ a. 72% of those surveyed experienced pain in the last month;
   ○ b. 42% were experiencing pain on the day of the survey;
   ○ c. 8% of those in pain went to a physician right away;
   ○ d. only b and c.

3. Texas is the first state to pass an Intractable Pain Treatment Act.
   ○ True
   ○ False

4. Pain research has shown that undertreated pain may lead to consequences such as
   ○ a. significant levels of depression and anxiety;
   ○ b. decreased ability to concentrate;
   ○ c. inability to function at home or work;
   ○ d. all of the above.

5. The Texas Medical Board guidelines include a chapter specifically addressing pain management.
   ○ True
   ○ False

6. Among the "Four A's" described by Guarino and Myers are
   ○ a. level of analgesia;
   ○ b. adverse effects;
   ○ c. aberrant behavior;
   ○ d. all of the above.

Statement of completion
I attest to having spent ________________ hours in this CME activity.

Physician signature ____________________________ Date ____________________________

Treating your patient's pain
CME evaluation form
Please complete the following regarding the article, “Treating your patient’s pain.”
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

Treating your patient’s pain
Failure to review previous surgeon’s report

by Barbara Rose and Laura Brockway

Presentation

A 65-year-old man came to General Surgeon A due to recurrent paraesophageal hernia. The patient was having problems with dysphagia, vomiting, and chest pain. He had also recently been diagnosed with an occlusion of the left anterior descending coronary artery. The patient’s medical history included tobacco use, hypertension, and coronary artery disease.

Physician action

During this visit, the patient brought a recent upper GI esophageal study and the operative reports from his previous general surgeon who had performed a paraesophageal hernia repair. This surgery had occurred four years earlier and a right posterolateral thoracotomy approach was used to reduce most of the stomach, part of the transverse colon, and a large amount of small bowel that were incarcerated in the right thorax. The entire stomach could not be brought into the abdominal cavity so a Nissen fundoplication was performed and a short gastric pouch was left in the chest because the patient had a shortened esophagus. Consequently, the patient experienced recurrent bowel obstructions and problems with reflux and swallowing.

General Surgeon A testified that he reviewed the operative reports and returned the records to the patient. He referred the patient to a cardiologist for possible coronary artery bypass.

The patient returned to General Surgeon A seven months later, after the bypass surgery. He had a ventral hernia and still reported problems with dysphagia. General Surgeon A’s notes did not include information on the patient’s medical and surgical history or findings from a physical examination. The record only indicated that the paraesophageal hernia needed to be repaired, as well as a ventral hernia.

General Surgeon A prescribed Neomycin and Erythromycin and gave the patient instructions for the bowel prep the day before surgery. The surgery was scheduled and General Surgeon A testified that he was not performing a re-do of the Nissen fundoplication. He planned to take down the existing Nissen wrap and pull the plaintiff’s stomach through the diaphragm for proper placement in the abdomen.

The surgery began, but General Surgeon A encountered dense adhesions. It took approximately two hours to complete the initial dissection. General Surgeon A consulted with a gastroenterologist who performed an intraoperative EGD that showed a stricture of the esophagus due to scarring. General Surgeon A was able to loosen and partially take down the existing Nissen wrap, but he could not proceed above the diaphragm due to the distorted anatomy. In his efforts to proceed, the vena cava was nicked. A cardiothoracic surgeon was consulted to repair it. General Surgeon A continued his surgery and while trying to repair the ventral hernia, he nicked the bowel. The abdominal cavity was contaminated and the procedure was stopped. General Surgeon A felt another procedure would need to be done through the chest, and the patient would need to undergo another ventral hernia repair since mesh was not placed. The abdomen was irrigated and the abdominal cavity closed. The patient tolerated the procedure well.

Postoperatively, the patient’s condition gradually improved and he was discharged seven days after the surgery. Six days after his discharge, the patient was seen in General Surgeon A’s office. The abdominal staples and drain were removed. The patient had no complaints. A week passed and the patient returned unexpectedly to General Surgeon A with significant abdominal pain. In a brief note, the surgeon indicated that he felt the patient had bad gas pain. He prescribed Reglan and Darvocet.

Later that evening, the patient went to the emergency department of a local hospital complaining of abdominal pain and nausea with vomiting for the last three to five days. The patient’s vital signs were normal and his white blood count was minimally elevated. The patient was admitted for pain control and to confirm a diagnosis. A CT scan revealed a hematoma. General Surgeon A saw the patient the next day and then turned his care over to General Surgeon B. This surgeon conducted an abdominal exam and determined that the patient was septic. General Surgeon B performed an exploratory laparotomy. The hematoma was evacuated, but dense adhesions prevented General Surgeon B from further exploration. An intraoperative EGD revealed ulceration of the stomach likely due to ischemia. General Surgeon B diagnosed a frozen abdomen due to gastric emphysema and the surgery was aborted. The patient was returned to ICU where he was put on a ventilator.

The patient’s family elected to take him home, and six days later he was discharged home with hospice care. He died two days later.

Allegations

A lawsuit was filed against General Surgeon A. The allegations included:

• failure to review the previous surgeon’s operative reports and medical records before embarking on the initial surgery;
• failure to document physical examinations;
• failure to order appropriate preoperative tests; and
• failure to properly monitor the patient during the postoperative period.

continued on page 16

These closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. These cases illustrate how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians’ defensibility. The ultimate goal in presenting these cases is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.
Failure to consult and diagnose
by Barbara Rose and Dana Leidig

Presentation and physician action
On January 15, a 66-year-old woman came to her physician—Family Physician A—with complaints of weight loss, vomiting, nausea, and loose stools since December 2000. Her weight at this examination was 98.5 pounds. She was noted to be a smoker. Lab tests were ordered, including CBC, metabolic panel, amylase, and thyroid function. Test results were within normal limits.

In May, the patient returned to Family Physician A complaining of weight loss and weakness. She continued to smoke and expressed feelings of anxiety and depression. A chest x-ray was ordered which showed COPD. She was given samples of Paxil, and asked to follow up in one month. She returned one month later still complaining of weight loss and diarrhea. The results from her abdominal exam were unremarkable. She was diagnosed with weight loss and given a prescription for Flagyl and Paxil. A CBC was also ordered at this visit. The results from her CBC were normal and she was instructed to follow up again in one month.

The patient returned to Family Physician A on July 6 still complaining of loss of appetite, weight loss, nausea, vomiting, and abdominal pain. Her weight was recorded as 85 pounds. She was diagnosed with progressive weight loss and tests were ordered, including a contrast CT scan of the abdomen and pelvis, a basic metabolic panel, and upper GI with small bowel follow through. The CT scan of the abdomen revealed both splenic and hepatic granulomas and arteriosclerotic calcifications of the aorta with no aneurysm present. The CT scan of the pelvis showed vascular calcification without any pathologic soft tissue mass. The results of the upper GI were normal.

The patient saw Family Physician A again on August 7, complaining of weight loss and a poor sense of well-being. Her weight had declined to 76 pounds by the August 7 visit. An abdominal ultrasound was conducted, revealing both splenic and hepatic granulomas, but was otherwise noted as unremarkable.

Approximately one week later, the patient returned to Family Physician A’s office complaining of weakness, nausea, and feeling faint. At this visit, she saw Family Physician B. He found the patient to be cachectic, and diagnosed chronic intermittent diarrhea, progressive weight loss, and smoking. The results from her abdominal exam were unremarkable. He referred the patient to a gastroenterologist.

Subsequently, there was an undated phone message from the patient indicating complaints of vomiting and diarrhea. It was believed that this message was left on August 16. The patient was instructed to go to the emergency department.

On August 16, the patient was admitted to the hospital for an upper endoscopy (with biopsies of the stomach and duodenum) and a colonoscopy (with biopsies of the colon and rectum). The pathology report indicated ischemic necrosis of the stomach and ischemic colitis. Parenteral nutrition was started. An angiogram was conducted, showing chronic mesenteric ischemia, occlusion of the superior mesenteric and inferior mesenteric arteries at their origins and high grade stenosis of the celiac axis.

The patient underwent surgery for a vascular bypass, where a necrotic bowel was discovered and resected. Her condition did not improve. A CT scan of her abdomen on August 23 showed the stomach and duodenum to have edematous changes, indicating possible infarction and a potentially infected intra-abdominal field. The patient died. Her death certificate listed the cause of death as liver failure due to gastric, intestinal, and hepatic infarction due to atherosclerosis.

Allegations
A lawsuit was filed against Family Physician A. The allegations were failure to timely consult with a specialist and failure to timely order diagnostic studies.

Legal implications
The plaintiff’s expert stated that Family Physician A failed to establish a differential diagnosis that would have led to a systematic evaluation of the patient’s complaints, particularly her significant weight loss and chronic abdominal pain. Additionally, if angiography had been ordered timely, then appropriate medical intervention may have prevented the death of this patient.

Defense experts had somewhat differing opinions about Family Physician A’s care of the patient. One defense expert felt that, although Family Physician A provided reasonable care, he was slow to perceive the seriousness of the patient’s condition. Another expert felt that, as of August 7, the treating physician should have referred this patient to a specialist or ordered additional testing. There were also differing opinions as to whether an earlier diagnosis would have improved the patient’s chance of survival.

Disposition
This case was settled on behalf of Family Physician A.

Risk management considerations
When caring for patients with multiple visits for chronic complaints, ensure clear and complete documentation in the medical record for each visit. Recording in the medical record an in-depth patient history, including a thorough review of symptoms, family history, medication history, and dietary history can assist in establishing a differential diagnosis as well as provide defensibility in the event of a claim.

When a patient with recurring symptoms returns to his or her physician and no definite diagnosis can be made, a referral to a specialist may be warranted.

Though it did not affect the outcome of this case, the undated phone message was referenced in the summary. Every entry in a medical record must include the date as a factual reflection and to avoid future conjecture.

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Legal implications
The plaintiff’s expert was critical of General Surgeon A for not reviewing the patient’s prior records. (The defendant testified that he reviewed the operative report during the patient’s first visit; however, the defendant’s notes did not include information on the patient’s medical and surgical history.) The plaintiff’s expert believed that it was the standard of care when taking care of a patient who exhibits complications from a previous surgery to find out what happened during the initial surgery. This expert stated that the surgeon should call the previous surgeon and discuss the patient’s procedure to find out how he did the surgery; the approach used; and if there were any problems during the initial surgery. This expert conceded that the prior surgeon’s treatment greatly contributed to the patient’s condition when he came to General Surgeon A. He also stated that the initial surgery was probably not necessary.

The defense argued that the patient’s prior medical history, his condition and symptoms when he came to General Surgeon A, and his subsequent care during his final hospitalization demonstrated the severity of the patient’s abdominal and esophageal condition before General Surgeon A’s involvement. A defense general surgery expert and a number of the patient’s subsequent physicians did not feel the patient’s frozen abdomen was due to General Surgeon A’s surgery. It was also stated that the subsequent problems the patient developed with frozen abdomen and gastric emphysema are difficult to manage and generally have poor outcomes no matter what is done.

Disposition
This case was taken to trial and the jury reached a verdict in favor of the plaintiffs. When polled, the jurors indicated that General Surgeon A’s preoperative work up was lacking and inadequate when compared to that performed by the patient’s previous surgeon. The jurors felt General Surgeon A should have ordered more tests and documented his physical examination better.

They also stated that when the patient returned two weeks after his discharge complaining of pain, General Surgeon A should have done more than prescribe medications. In their opinion, the patient should have been admitted and the defendant should have ordered tests to determine the cause of the patient’s pain.

A settlement was reached two days after the verdict.

Risk management considerations
Whether a brief or long-term physician/patient relationship, when a patient seeks the care of a physician, the medical record is expected to include a comprehensive medical-surgical history and a current physical examination with the findings described in detail. This information is needed to substantiate the physician’s recommended plan of care for the patient.

Based on the postverdict discussion with the jurors, it would appear that documentation issues did affect the jury’s decision. The advantages of a detailed and comprehensive medical record are not to be disputed as memories fade with time. All physicians are expected to be familiar with chapter 165 of the Texas Medical Board rules regarding documentation.

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