The TMLT risk management department frequently receives calls from physicians who are seeking advice about how to handle difficult patients. Often, these physicians are “at the end of their rope.” They describe patients who are rude or disruptive; who fail to keep appointments; who refuse to adhere to practice policies; or who simply will not follow the treatment plan. These patients can leave physicians with no other viable alternative than to terminate the physician-patient relationship. This article will discuss the physician-patient relationship, provide guidelines for ending the relationship, and will describe the process for dismissing a patient.

Ending the physician-patient relationship

“The physician-patient relationship is the result of a contract, express or implied, between a physician and patient that is voluntary and arises when a patient requests and is supplied medical information/treatment.”

While both the physician and patient have the right to terminate the relationship, the requirements for ending the relationship are more complicated for physicians. Physicians need to follow a process of proper documentation and adequate notice to avoid allegations of patient abandonment. According to Texas Medical Jurisprudence, a patient may have a cause of action for abandonment when “without reasonable notice to the patient, a physician unilaterally discontinues treatment at a time when continued medical treatment is necessary.”

“A physician’s obligation of continuing medical attention can be terminated only by: (a) cessation of the medical necessity which gave rise to the physician-patient relationship; (b) discharge of the physician by the patient, or when a patient voluntarily chooses not to return to his physician; or (c) withdrawal from the

continued on page 2
case by the physician after giving the patient reasonable notice, so as to enable the patient to secure other medical attention.”

**Guidelines**

Patient noncompliance is a main reason physicians give for wanting to dismiss patients. Other reasons include failure to keep appointments, rude behavior, or failure to pay an outstanding balance. When deciding whether or not to dismiss a patient the physician must consider the patient’s medical status and needs. According to Jane Holeman, vice president of risk management at TMLT, there are situations in which a physician cannot dissolve the physician-patient relationship. These may include when the physician is on call in the emergency department, when the physician is treating a hospitalized patient, or when a surgeon is treating a patient postoperatively.

“The physician must care for the patient until he or she is stabilized or until another physician is found to assume that person’s care. Surgeons (or those covering for them) have an obligation to see patients after surgery until postoperative care is no longer required, the patient is stable, and can be discharged from their care,” says Holeman.

A common question received in the risk management department involves when an on-call specialist can dismiss a patient. “For example, the orthopedic surgeon who is on-call in the ED and sees a patient with a broken leg must care for the patient through that acute episode. In general, the physician must see the patient for follow up until he or she is stabilized from that event,” says Holeman. In this example, the orthopedic surgeon is only obligated to treat the patient for the broken leg and generally would not have to treat the patient for any unrelated condition. Physicians are encouraged to review the terms of their on-call contracts with the hospital to determine specific responsibilities for follow up.

For obstetricians, it is not advisable to dismiss a patient who is beyond the 28th week of the pregnancy. The patient needs to continue prenatal care and other obstetricians may not accept the patient this late in the pregnancy. “After the 28th week, you will likely need to care for the patient through the six-week postpartum visit,” says Holeman. “Additionally, if the patient was dismissed early in the pregnancy and you are on call when the patient shows up in labor and delivery, you must see the patient.”

It can also be difficult for a member of a physician group to dismiss a patient. If the patient needs care and the dismissing physician is on call for the group, that physician will have to see the patient. “To avoid this, the patient should be formally dismissed from the group and not just from the individual physician’s care,” says Holeman.

Physicians who practice in rural areas may not have the option of dismissing patients. “Many rural physicians do not discharge patients because they are the only physician in town,” says Holeman. “In this situation, if the patient is noncompliant or fails to show for appointments, the physician should thoroughly document any counseling or patient instructions. The burden is on the physician to document the interactions and medical management of that patient.”

Another frequently asked question involves the obligation of the physician to the patient after the patient has filed a lawsuit or a complaint with the Texas Medical Board against the physician. According to Holeman, litigation or a complaint filed by a patient does not automatically terminate the physician-patient relationship. “The physician is still obligated to see the patient until the relationship has been properly terminated. Even though the patient is suing, the physician would still need to go through the dismissal process,” says Holeman.

Physicians should also be aware that some provider contracts — Medicare, Medicaid, and private health insurance plans — may stipulate that the physician must accept certain patients and specify the steps the physician must follow in order to dismiss a patient.

“These organizations may require you to contact them before you discharge the patient so they can be sure that you are not discharging the patient because they have certain insurance coverage. Though this is probably not a common stipulation, physicians should be familiar with the terms of their provider contracts before starting the dismissal process,” says Holeman.

Additionally, because physicians’ offices are subject to state and federal civil rights laws, a patient cannot be dismissed because he or she has been diagnosed with HIV/AIDS or because of “race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.” 2-3 “This does not mean that patients belonging to these classifications cannot be dismissed, but only that they cannot be dismissed because of their classification,” says Holeman. “If a physician is considering dismissing a patient who is in a protected class or is disabled, he or she may want to consult an attorney to assess the liability risk.”

**The process**

Risk managers recommend that physicians develop a standardized process for dismissing patients. “As a first step in this process, we advise that physicians go through a counseling process with the patient, particularly if the patient is noncompliant. In addition to explaining the potential health consequences of continued noncompliance, tell the patient you may have to terminate the relationship if the patient does not comply. Have this conversation with the patient more than once and document it in the medical record,” says Holeman. In certain circumstances, the physician may want to have a witness, such as a nurse, present.

Physicians who are tempted to forego the counseling process may be missing an opportunity to understand the cause of the patient’s noncompliance. “Taking time to sit down with the patient with the goal of better understanding the underlying expectations or needs that are driving his or her behavior can be valuable. Some patients have unreasonable expectations, but for others, understanding the point they’re trying to make can go a long way in repairing

“We When deciding whether or not to dismiss a patient the physician must consider the patient’s medical status and needs.”
the relationship. Learning about the root cause of their dissatisfaction can help us improve the delivery of care to all our patients.4

A similar counseling process should be employed for patients who miss appointments or who exhibit rude behavior. “Direct statements such as, ‘If you do this again, we will no longer care for you,’ and ‘You will have to go to another practice,’ can be quite eye-opening for some patients.”4 Again, document these discussions in the record.

If the counseling process is not effective and the physician decides to dismiss the patient, the next step is to send a dismissal letter to the patient. The letter should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. The dismissal letter should include the following elements. (Please see sample letter on page 4).

• A statement that the physician-patient relationship will terminate in a specified time period and a recommendation that the patient find another physician. The time limit given in the letter will depend on several factors such as physician specialty, size of community, and availability of other physicians. The patient should be given a reasonable amount of time to find a new physician. The current physician should remain available for care until the specified time period elapses.

• The physician is not required to state a reason for the termination. In general, risk managers advise against including a reason unless it can be stated in a brief, clear, and objective way. “Some physicians are angry and want to include the reason for the dismissal in the letter using very disparaging language. We recommend that these remarks not be put in writing,” says Holeman.

• Describe in general terms how the patient can locate a new physician. It is not advisable to name a specific physician, clinic, or group. Refer the patient to his or her health insurance company’s list of providers, county medical society, or a physician-referral service.

• Include an authorization for the release of the medical record. Advise the patient to designate the new physician, sign the form, and send it to your office promptly. Indicate in the letter that the record will be copied and forwarded to the physician as soon as possible. “If a patient requests the record be released directly to him or her, it is advisable not to charge the patient for copying the records because it could inflame the situation further. Provide the first copy of the record as a courtesy and then decide whether or not to charge after that,” says Holeman.

Keep a copy of the dismissal letter and the return receipt in the patient’s medical record. Once the time period specified in the letter has passed, the physician is no longer required to treat the patient.

A similar process should be followed if the patient dismisses the physician. “If a patient tells the physician that he is never going to return to the office, the physician should send a letter to confirm that the patient has terminated the relationship,” says Holeman. (Please see sample letter on page 4.)

Another problematic situation can arise after the patient has been dismissed — the patient comes to the ED and the dismissing physician is on call. “When this happens, the physician has to treat the patient, but we recommend that he or she send a follow-up letter to the patient saying that though the patient was treated in an emergency situation, the relationship remains terminated,” says Holeman.

A final step in the termination process that can be over-looked — inform office staff, especially the appointment scheduler, about the dismissal. Advise staff not to schedule the patient after the effective termination date.

**Dismissal for nonpayment**

Patients can be dismissed from a practice for nonpayment of fees, but this situation must be handled very carefully. “The physician should closely evaluate the need for continuity of care, and it is strongly recommended that dismissal for this reason only be used as a last resort,” says Holeman.

“As a corollary, a physician should not deny an established patient an appointment or cancel an appointment because of an unpaid balance. So long as the physician-patient relationship is established and not definitively terminated, a physician owes the patient the same duty of care, otherwise there is a danger of abandonment . . . a person is a patient for all purposes regardless of their pay status until the relationship is terminated.”5

The first step in dismissing a patient for nonpayment involves a counseling process with the patient. “We recommend that the patient be given reasonable opportunity or time to take care of the outstanding balance before the patient is dismissed,” says Holeman. This discussion with the patient should be documented, but it should not be included in the patient care portion of the medical record. Maintain this documentation with the billing information.

If the patient still does not comply after being given a reasonable opportunity to do so and the physician has determined that the continuity of care will not be compromised, send the patient a letter stating that the physician-patient relationship will be terminated if the patient does not respond. (Please see sample letter on page 4.)

If the patient does not contact the office in response to the first letter, send a second letter stating that the physician-patient relationship has been terminated. (Please see sample letter on page 4.)

Both letters should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. Place copies of these letters in the patient’s medical records.

If the patient does contact the office and requests copies of the medical records, be aware that the patient’s record cannot be withheld from another physician or from the patient because of an overdue account.

“Following this process will help physicians counsel patients to change their behavior, provide fair warning to patients and allow them time to find another physician, and will help ensure that the physician is not abandoning the patient,” says Holeman.

**Sources**


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Sample termination letters

When the physician decides to dismiss a patient, the patient should be notified in writing. The letter should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. Physicians can adapt the following sample letters.

**Termination of the physician/patient relationship**

Date
[patient address]  Certified receipt # ___________
[patient address]  Also sent first-class mail.

Dear [patient name]:

Please be advised that I will no longer be able to treat you as a patient. The termination of our physician/patient relationship will be effective in 30 days from the date of this letter. Your medical condition requires continuing physician supervision, and it is important that you select another physician as soon as possible.

Contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, a copy of your medical record will be sent to your new physician. A release form is enclosed.

Sincerely,
[physician name]

**Non-payment notice**

Date
[patient address]  Certified receipt # ___________
[patient address]  Also sent first-class mail.

Dear [patient name]:

It has come to my attention that you have received several letters regarding your outstanding account. If there has been a problem or if you are unhappy with the care that you have received in this practice, please contact me to discuss the situation. You are important to us, and I hope we can resolve any issues you have.

My business manager is also available to discuss payment of your account or to implement payment arrangements if they are needed. Should we not hear from you within 30 days, I believe that it would be mutually beneficial to terminate the physician/patient relationship so that you may locate a new physician.

I hope that we will hear from you in the near future

Sincerely,
[physician name]

**Confirmation of patient-terminated relationship**

Date
[patient address]  Certified receipt # ___________
[patient address]  Also sent regular mail.

Dear [patient name]:

This letter is sent to confirm your decision to discontinue care with me. Your medical condition requires physician supervision, and it is important that you select another physician as soon as possible. I will be available to you until [30 days from date of letter].

Please contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, I will provide a copy of your medical record to your new physician. A release form is enclosed to expedite the process.

Sincerely,
[physician name]

**Termination for non-payment**

Date
[patient address]  Certified receipt # ___________
[patient address]  Also sent regular mail.

Dear [patient name]:

On [date], I sent you a letter requesting that you contact the business manager or me regarding any problems that may have occurred resulting in non-payment of your account. In the letter, I stated that it would be necessary to terminate our physician/patient relationship if we did not hear from you.

Since we have not heard from you, please be advised that I will no longer be able to treat you as a patient. The termination of our relationship will be effective in 30 days from the date of this letter.

A release form is enclosed for your written authorization. Please contact us with the name of your new physician so we may forward your records to his or her office. At that time, your account will be closed.

Sincerely,
[physician name]
Encourage your patients to Ask 3

by Dana Leidig, ABC

Communicating health information to your patients is something you do all day every day. Can you be sure that the medical language you use with your patients is clearly understood? Are patients able to read and comprehend the printed materials and forms you may provide them? How do you know?

Poor health literacy has been identified as a growing public health issue. It crosses all ages, nationalities, and socioeconomic levels. Surprisingly, a patient’s degree of education is not a reliable indicator of his or her ability to understand the health information that you provide. Low health literacy has a costly impact on our health care system. “Individuals with limited health literacy incur medical expenses that are up to four times greater than patients with adequate literacy skills, costing the health care system billions of dollars every year in unnecessary doctor visits and hospital stays.”

Patients who do not adequately understand their diagnosis and treatment may even contribute to medical errors by failing to communicate important information to their health care professional. “Low literacy plays an important role in health disparities and may contribute to lower quality care and even medical errors,” said Dr. Carolyn M. Clancy, director of the Agency for Healthcare Research and Quality.

Patients may be unsure of the kinds of questions to ask their physicians during appointments or when they are scheduled for a medical test or procedure. Their physician may be explaining multiple health conditions and treatments that are difficult to grasp, or their diagnosis may cause fear or shock. They may feel intimidated by the medical language used and embarrassed that they are having difficulty understanding. When patients pick up prescription medications, they may not know the questions they should be asking their pharmacist. Statistics from the Center for Health Care Strategies, Inc. indicate that only half of all patients follow directions when taking medications.

To address these issues, the Partnership for Clear Health Communication at the National Patient Safety Foundation has developed an educational program called Ask Me 3 “to promote clear communication between patients and providers.”

Experts from this coalition developed three questions that patients should always ask their health care professional and that health care professionals should assist their patients in understanding. The three questions are:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

The Ask Me 3 web site (www.askme3.org) provides patients with information on how to communicate with their medical professional and promotes the idea of “good questions for your good health.” It outlines for the patient the best time to ask questions and what to do if he or she still does not understand.

One section of this web site that may be particularly enlightening for health care professionals is the “Words to Watch Fact Sheet.” Here, common problem medical words, concept words, category words, and value judgment words are identified, and a list of alternative, more familiar words for patients is substituted. An awareness that some Latin or Greek words may be confusing to patients or that common words may take on a different meaning is helpful when communicating with patients. A sampling from this section includes:

<table>
<thead>
<tr>
<th>Problem Word</th>
<th>Consider Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical word:</td>
<td></td>
</tr>
<tr>
<td>Benign</td>
<td>Will not cause harm; is not cancer</td>
</tr>
<tr>
<td>Dysfunction</td>
<td></td>
</tr>
<tr>
<td>Concept word:</td>
<td></td>
</tr>
<tr>
<td>Avoid</td>
<td>Stay away from; do not use (or eat)</td>
</tr>
<tr>
<td>Gauge</td>
<td>Measure; test; get a better idea of</td>
</tr>
<tr>
<td>Category word:</td>
<td></td>
</tr>
<tr>
<td>Adverse (reaction)</td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td>Learning; thinking</td>
</tr>
<tr>
<td>Value judgment word:</td>
<td></td>
</tr>
<tr>
<td>Cautiously</td>
<td>With care; slowly</td>
</tr>
<tr>
<td>Excessive</td>
<td>Too much</td>
</tr>
</tbody>
</table>

In addition, to facilitate greater understanding, health care professionals are encouraged to use examples or visual aids with patients when explaining health conditions and treatment plans.

Former Surgeon General Richard H. Carmona, said “health literacy is the currency of success for everything that we do in primary and preventive medicine. Health literacy can save lives, save money, and improve the health and well-being of millions of Americans. All of us — government, academia, health care professionals, corporations, communities, and consumers — working together can bridge the gap between what health professionals know and what patients understand, and thereby improve the health of all Americans.”

Sources

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Boomers come of (retirement) age

health care workforce shortages, chronic illness among the challenges

Course author
Marsha Freeman is a risk management representative at TMLT.

Disclosure
Marsha Freeman 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 June 2, 2008 and expires on June 2, 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. identify the demographic age range of the baby boom generation;
2. list the chronic health conditions that will likely be prevalent in baby boomers as they age;
3. describe how health care workforce shortages will affect the care of baby boomers; and
4. discuss how baby boomers could influence the health care delivery system.

### Introduction

“In 1946, 3.4 million babies were born in the U.S., a jump of 22% from the previous year. The surge of births continued until 1964. By that time 78 million ‘baby boomers’ had joined the population, creating a huge demographic bulge that flourished in America’s postwar prosperity.”

According to the Census Bureau, as of July 1, 2005, there were 78.2 million baby boomers in the U.S. The first group of boomers will reach age 65 in 2011. By 2020, researchers project 50 million Americans will be 65 or older. By 2030, the number of Americans older than 65 will have grown by 75% to 69 million. That means more than 20% of the population will be older than 65 (compared with 13%) and more than 35% of Americans will be older than 50. Boomers are expected to live longer than any previous generation of Americans. Of the 3.4 million born in 1946, 2.8 million are still alive.

In our current decade, “the highest growth rate in the U.S. workforce will be among workers age 55-64. In 2000, 13% of the workforce was 55 and older. By 2010, this figure will rise to 17%, or 26.6 million workers. By 2015, nearly one in five workers will be 55 or older. During that time, the number of younger workers, those aged 25-44, will actually decrease.”

Thanks to medical science, we are experiencing not only an extension of the average human life span, but we are seeing far greater numbers of healthy, educated older people in our society. Aging, as we have known it, will no longer be seen as a time of disability, mental decline, and diminished energy. Many people will remain active and alert into a second century.

Boomers will enjoy not just increased longevity, but better health as well. “People are living longer because of both lifestyle changes and advances in health care. Thanks to major advances in medicine, fewer people die at an early age from heart disease and cancer.”

As the percentage of older Americans increases, the debate over how or who will finance retirement and health care costs is ongoing. The federal government has projected that expenditures for Medicare and Social Security will increase by 167% by 2030, that Medicare’s hospital trust fund will go bankrupt by 2010, and that Social Security will be unable to pay all of its promised benefits in 2032.

In April 2008, the Institute of Medicine (IOM) issued a report describing the “impending crisis” in the health care system as the number of older patients continues to grow. The report, “Retooling for an Aging America: Building the Health Care Workforce,” calls for higher pay, more training, and changes in care delivery to prevent the crisis. (Please see page 8 for more information on the IOM report.)

### Effects on the health care system

“Although the health and lifestyle of people at age 65 is very different than it was in generations past — it’s even been said that ‘60 is the new 50’ — the reality remains that chronic conditions continue to plague the population.”

According to the American Hospital Association (AHA), by 2030 more than 37 million boomers will be managing more than one chronic condition: more than 21 million will be considered obese; 14 million will have diabetes; 26 million will have arthritis.

Currently, chronic conditions are the primary reason why older adults seek medical care. According to the IOM report, Medicare beneficiaries with more than one chronic condition visit an average of eight physicians in a year. The 20 percent of Medicare beneficiaries with five or more chronic conditions account for two-thirds of Medicare spending.

Approximately 20 percent of adults ages 55 and older have a mental health condition. The most common conditions for this age group are anxiety disorders, severe cognitive impairment, and mood disorders. “Vulnerability to mental health conditions tends to increase as older adults age and become more likely to encounter stressful events, including declines in health and the loss of loved ones.”

“Since the biggest factors influencing medical spending are chronic illness and a patient’s level of disability, the growing incidence of multiple chronic conditions will put increasing demands on our health care system. Boomers will require more care, different types of care and better coordination of care.”

Paul Hodge, director of the Harvard Generations Policy Program at Harvard University told the Wall Street Journal “As boomers age, the cost of medical goods and services will strain our health care system, including Medicare and Medicaid. As a result, our focus on treating diseases and illnesses will shift to prevention and promoting healthy lifestyles.”

According to the AHA report “When I’m 64: How boomers will change health care,” hospital admissions among baby boomers will double by the year 2030. Also by 2030, the number of physician visits by adults will double and boomers will account for more than 40% of these visits. “The high levels of chronic disease in the boomer population will increase the need for tests and procedures. For example, in 2030, if all boomers with diabetes receive recommended care, they will need 55 million laboratory tests per year — 44 million more than today.”

“Older people have medical needs different from younger adults. The average


**Recommendations from the Institute of Medicine**

As the first of the baby boomers begin to turn 65 in 2011, they will face a health care work force that is too small and “woefully unprepared” to meet their specific health needs, according to a report from the Institute of Medicine. The report, “Retooling for an Aging America: Building the Health Care Workforce,” makes specific recommendations for enhancing the geriatric competence of the entire workforce, increasing the recruitment and retention of geriatric specialists, and improving the ways health care is delivered. Some of these recommendations are summarized below.

**Enhancing geriatric competence**

“Since virtually all health care professionals care for older adults to some degree, geriatric competence needs to be improved through significant enhancements in educational curricula and training programs.”

“**Recommendation 4.1:** Hospitals should encourage the training of residents in all settings where older adults receive care, including nursing homes, assisted-living facilities, and patients’ homes.

**Recommendation 4.2:** All licensure, certification, and maintenance of certification for health care professionals should include demonstration of competence in the care of older adults as a criterion.

**Recommendation 5.1:** States and federal government should increase minimum training standards for all direct-care workers.

**Recommendation 6.2:** Public, private, and community organizations should provide funding and ensure that adequate training opportunities are available in the community for informal caregivers.”

**Increased recruitment and retention**

“Geriatric specialists are needed in all professions not only for their clinical experience, but also because they will be responsible to train the entire workforce in geriatric principles. However, only a small percentage of professional health care providers specialize in geriatrics, in part due to the high cost associated with the extra years of training as well as the relatively low pay.”

“**Recommendation 4.3:** Public and private payers should provide financial incentives to increase the number of geriatric specialists in all health professions.

**Recommendation 4.3a:** All payers should include a specific enhancement of reimbursement for clinical services delivered to older adults by practitioners with a certification of special expertise in geriatrics.

**Recommendation 4.3c:** States and the federal government should institute programs for loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists. One such mechanism should include the development of a National Geriatric Service Corps, modeled after the National Health Service Corps.

**Recommendation 5.2:** State Medicaid programs should increase pay and fringe benefits for direct-care workers through such measures as wage pass-throughs, setting wage floors, establishing minimum percentages of service rates directed to direct-care labor costs, and other means.”

75-year-old person has three chronic medical conditions and regularly uses about five prescription drugs, as well as multiple over-the-counter remedies. Changes with aging can alter how the body metabolizes, absorbs, and clears these drugs from the body. Also, symptoms of illness can present differently in older people than in the young or middle-aged.”

The effects of the “graying” patient population are already being seen in emergency departments. “Emergency departments (EDs), already staggering under the load of boarded inpatients, unfunded federal mandates and the uninsured, have another challenge looming . . . if the trend continues, the researchers say, the number of senior visitors to the ED could rise from 6.4 million to 11.7 million by 2013.”

The effects on overburdened EDs and hospitals, “could be catastrophic, citing the urgent need for planning now.” Older patients not only require greater resources, but they have distinct care needs that often do not fit into the disease and episode model followed by most EDs.

“Little things become a big deal when working regularly with older patients. A physician or nurse can simply hand a younger patient a gown and point them to a stretcher, and return in 5 minutes. That doesn’t work with older patients . . . Asking simple questions can become difficult too. Most adults can easily cite their medications, if any. A senior citizen might have a purse full of them.”

Researchers also predict an increased need for palliative and end-of-life care as boomers age. “Boomers who have participated in providing care for a loved one will be more likely to plan for and discuss with their family their wishes for their own end-of-life care. More and more people will be in need of and use palliative care.”

**Health care workforce shortage**

The ability to meet this increased demand for health care services will be compromised by workforce shortages. In 2005, there was a shortage of 220,000 registered nurses in the U.S. By 2020, there will be a shortage of more than 1 million nurses. “More recent studies have indicated that the nursing shortage may be only half of what was originally projected, or occur later than predicted due to nurses staying in the workforce longer and more people entering nursing in their late twenties. But under either scenario, a huge need remains.”

The American Hospital Association also
points out that there are currently shortages in other health care professions. “As of December 2006, while over 8 percent of nursing positions were vacant, 8 percent of pharmacist positions also were vacant and nearly 6 percent of laboratory and imaging technician jobs were not filled.” 4

The physician shortage is also expected to increase as the population ages. By 2020, there will be a gap of 130,000 specialists and a gap of more than 60,000 primary care physicians. “Physician shortages are projected to be most severe in the specialties that older boomers need the most. There is already a shortage of geriatricians . . . and the supply is actually declining. One-third of current training program positions for geriatricians are not filled. Even if the number of geriatric specialists remains stable, there will be a shortage of almost 20,000 by 2015.” 4

Only three of the nation’s 145 medical schools have full-scale geriatrics departments that require a mandatory rotation in geriatrics for students and residents. Less than 3% of all medical students take even one course in geriatrics. “Currently, only one in 5,000 adults age 65 and older is under a geriatrician’s care. And with the expected swell in that population as the baby boomers enter their senior years, we need more geriatricians and more of our primary care physicians need geriatric training. One of the main reasons for the shortage is that medical residents aren’t choosing geriatrics as a specialty, due to poor reimbursement and the increased demands of the older patients.” 12

Chronic disease among aging baby boomers will increase the demand for specialists. More endocrinologists will be needed to treat patients with diabetes. More rheumatologists will be needed to treat patients with arthritis. More cardiologists will be needed to treat heart disease. More orthopedic surgeons will be needed to meet increased demand for the two most common orthopedic procedures — hip and knee replacements. 4

“Although schools of medicine, nursing and social work are beginning to take steps to attract new students to the field of geriatrics, it is imperative that the existing health care workforce — practicing physicians, nurses, therapists, pharmacists, and social workers — receive the training and education necessary to address the needs of their expanding pool of older patients.” 21

The complex needs of older patients can be effectively managed and the quality of life maintained by health care professionals who are trained in geriatrics. “For many older people, chronic age-related conditions such as memory loss, depression, or incontinence, pose a direct threat to their ability to live independently. Careful management of these conditions by a multi-disciplinary team become paramount to maintaining long-term health, vigor and the capacity for personal growth and independence.” 9

The financial benefits of care provided by geriatric-trained health care workers and physicians are potentially enormous. The Alliance for Aging Research estimates that proper geriatric care could reduce hospital, nursing home, and home care costs by at least 10% a year. “Often the key to effective management of the complex and over-lapping health challenges of older patients is a health care professional who has at least some training and orientation in geriatric health care.” 9

As the boomers age, there will be an increase in the number of office visits, medical procedures, screening tests, and immunizations. As more people live longer, the need for assisted living, skilled nursing, Alzheimer’s care, hospice, and palliative care will grow. In fact, everything seems to be increasing except for the number of professionals who can meet the need.

The health care workforce is unable to keep up. Current shortages of primary care doctors and nurses will get worse. Fewer students are choosing primary care as their specialty, and fewer individuals are entering nursing as a profession. And since many physicians and nurses are boomers themselves, the expected attrition through retirement of health professionals means that the demand for care will exceed the supply.

**Medicare**

It is impossible to discuss the influence baby boomers will have on health care without exploring Medicare. This discussion is so vast and complicated that volumes of research, white papers, opinions, strategies, legislation, and reports continue to support and contradict each other. “Changes in Medicare or Medicaid policies could also have a significant effect on service utilization by older adults — and, given that a severe cost crisis in the Medicare program is widely expected, such changes are likely.” 6

According to the IOM report, in 1999 per capita health care spending was $44,520. Medicare pays for 52% of health care costs in older adults; Medicaid pays for 12 percent. 6 In 2006, Medicare paid $406 billion in benefits. “The hospital insurance trust fund, which funds Medicare Part A, is projected to be exhausted by 2019. The financial outlook for Medicaid is hardly better. Medicaid is the second largest program in state budgets, growing faster than other state programs. The budgetary situation of these two programs is dismal, and policy changes will likely occur prior to 2030 in order to address them.” 6

As is often the case in health care, the measures proposed to slow the rate of spending in Medicare and Medicaid — such as reductions in eligibility and benefits — can lead to increased costs in the future. “Insufficient funding for Medicare and Medicaid will place strains on the ability of health care professionals to provide health care services. It will also exacerbate issues of recruitment and retention — a particular concern in the case of providers qualified in geriatrics, whose presence in the field is already dreadfully low. The financing of care is only part of the problem, however, and simply allocating more funding or resources will not fully address the deficiencies in the care of older adults.” 6

**Transforming health care delivery**

Increasing demand, workforce shortages, and skyrocketing costs — sounds like a recipe for disaster. This “dooom and gloom” scenario has been expressed repeatedly when describing how aging boomers will affect health care. However, consider the possibility that boomers will be a transformational force in health care delivery.

The baby boomers represent the single largest demographic spike in American history. From popular culture to civil rights to religion and politics, this is a generation that has defined, and continues to define America’s culture. This generation has the money, the college education, the computer experience and the sheer numbers to transform the health care system. According to the Department of Labor’s Consumer Expenditure Survey, America’s baby boomers outspend other generations by an estimated $400 billion each year on consumer goods and services. 8 With education comes higher reading levels, higher-skill employment, and a better sense of how to find and use information to make decisions. The baby boomers may not be as technically adept as their children, but the vast majority is
developed the delivery system to do that.” 7

To improve health care delivery to address these chronic conditions, the AHA says that hospitals need to focus on forming community-based collaborations and strengthening outpatient services. National attention must be placed on how health care is paid for, and the boomer generation is the perfect group to advocate for change in this area. “When you think of the boomers, the first part of the group coming up in the 1960s, they were a generation that was involved in social change and social issues. . . today the needs are for massive change in the way health care is paid for and delivered and we’re going to need a strong wave of activism from the grassroots. The key will be motivating the boomers, who have a strong streak of political activism and many of whom who won’t yet be on Medicare, to have another national debate about health care reform.” 7

Conclusion

Some readers may view this article with doom and gloom, while others may see vast opportunities to meet the challenges described as the baby boomers reach retirement age. Irrespective of one’s mindset, the effect on the delivery of quality health care is daunting. It behooves us all to become informed, involved, and vocal in requesting corrective action from our government leaders.

Sources


Tips for communicating with patients as they age

An article published in Family Practice Management provided the following tips for physicians to help improve communication with older patients:

“1. Allow extra time for older patients.
2. Avoid distractions.
3. Sit face to face with the patient.
4. Maintain eye contact.
5. Listen without interrupting the patient.
6. Speak slowly, clearly, and loudly.
7. Simplify information by using short, simple words and sentences.
8. Stick to one topic at a time.
9. Simplify and write down your instructions.
10. Use charts, models, and pictures to illustrate your message.
11. Frequently summarize the most important points.
12. Give the patient a chance to ask questions.
13. Schedule older patients earlier in the day.
14. Greet them as they arrive at the practice.
15. Seat them in a quiet, comfortable area.
16. Make signs, forms and brochures easy to read.
17. Be prepared to escort elderly patients from room to room.
18. Check on them if they’ve been waiting in the exam room.
19. Use touch to keep the patient relaxed and focused.
20. Say goodbye to end the visit on a positive note.”

“Communication is not an exact science; you will need to experiment and find which strategies work best for you and your staff. However, if you begin with the tips provided and if you train your staff to follow them, you will find increased levels of comfort and satisfaction among your elderly patients, and you will be better able to care for this growing population.” 16
Legislation passed in recent years imposes new requirements on physicians who provide prenatal care to pregnant women.

Effective September 1, 2005, physicians, hospitals, birthing centers, and midwives who provide prenatal care to a pregnant woman during gestation or at delivery are required to provide the woman and her father or an adult caregiver with a resource pamphlet that includes information on postpartum depression, shaken baby syndrome, immunizations, and newborn screening.

The pamphlet, “Information for Parents of Newborn Children” is maintained by the Texas Department of State Health Services (DSHS) and is available at http://www.dshs.state.tx.us/mch/Parents_of_newborn.shtml.

It must be documented in the patient’s chart that she received this information, and the documentation must be retained for a minimum of five years. DSHS recommends that the information be given twice, at the first prenatal visit and again after delivery.

In an effort to ensure pregnant women are given balanced information on umbilical cord blood banking, the Texas legislature passed House Bill 709 in 2007. This legislation requires physicians or other persons permitted by law to attend a pregnant woman during gestation or at delivery shall provide the woman with a brochure on umbilical cord blood banking before the third trimester or as soon as reasonably feasible. The brochure, published by the DSHS, is available at http://www8.dshs.state.tx.us/mch/default.shtm.

In case you missed it

New requirements for physicians who provide prenatal care
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. What is the date range of births that determine the baby boom generation?
   ○ 1940-1955
   ○ 1946-1964
   ○ 1946-1960
   ○ 1949-1959

2. The focus on treating disease and illnesses with the baby boomers is taking a shift to prevention and promoting healthy lifestyles.
   ○ True
   ○ False

3. Baby boomers are changing the perception of aging.
   ○ True
   ○ False

4. The baby boomers represent the single largest demographic spike in American history.
   ○ True
   ○ False

5. Only a small share of the medical doctors in practice today receive the necessary training and education in geriatrics.
   ○ True
   ○ False

6. Geriatric-care teams can effectively manage the complex needs of older patients.
   ○ True
   ○ False

Statement of completion

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

Physician signature __________________________________________ Date ____________________

Baby boomers come of (retirement) age
CME evaluation form
Please complete the following regarding the article, "Boomers come of (retirement) age."
Please fax the completed evaluation with the CME test questions.

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

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

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

4. How long did it take you to complete this learning activity?
   O .5 hr  O .75 hr  O 1 hr  O 1.25 hrs  O 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?
   O 1  O 2  O 3  O 4  O 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?  O Yes  O No

"Boomers come of (retirement) age"
by Lesley Viner, MS

In 2007, the TMLT Risk Management Department offered policyholders an innovative aviation-based CME series entitled “Soaring Over the Safety and Quality Chasm: Using Teamwork and Communication to Reduce Medical Liability Risk and Improve Performance.” This article will summarize the content discussed in the 2007 program as well as offer additional insight from the speaker, Steven Montague, pilot and vice president of LifeWings Partners.

Can you tell me briefly about the recent history of the aviation safety movement? What have been the results/outcomes?

“In 1979, NASA convened a workshop on airline safety, the outgrowth of which was one important piece of data and a direct challenge. The data showed that 70% of airline accidents were due to human error in a team setting. The airlines were asked how to address this threat, and they were challenged to move forward and fix the problem. The resulting solution, known as Crew Resource Management (CRM), began to take on a life of its own. The results of this intervention can best be summarized by stating that one fatality has been experienced by a major U.S. commercial airline since 2001.

Desiring others to benefit from lessons learned, the airlines shared their experiences openly. LifeWings believes in this type of collaboration and works to facilitate the sharing of best practices between health care professionals and institutions.”

What does aviation safety have to do with medicine?

“Physicians and pilots both work in closely scrutinized environments with high degrees of interdependency on other professionals and agencies. The workplace is stressful, complex, and demands quick decision-making abilities that can often lead to potentially catastrophic outcomes. Also, just as aviators must often form a team in 90 seconds or less, clinicians are often called upon to quickly create an effective team with complete strangers comprising a wide variability in experience and qualification. While there are significant differences between health care and aviation, these similarities provide a very good fit for many of the strategies that have proven successful in aviation and other high reliability organizations.”

What specific techniques/strategies can physicians use?

“Physicians can benefit from utilizing a ‘huddle’ technique when teams come together to provide care to a patient. During these huddle sessions, physicians should articulate goals, assess team member capabilities and concerns, clarify roles and responsibilities, discuss likely contingencies that may arise, and create an atmosphere of open communication. These huddle sessions, when approached with structure and adequate training, can be accomplished in as little as one minute and result in increased efficiencies and better processes.

Physicians can also leverage their expertise, critical thinking, and team awareness when making decisions by engaging in well-designed processes that ensure the best decisions are made.”

In your opinion, what are physicians’ weakest areas when it comes to patient safety? Where does the most work need to be done?

“As is often the case, their greatest strength is their greatest weakness. Doctors are intelligent, dedicated, compassionate people who are trained to never make a mistake. This is very similar to the expectations that pilots place on themselves, and it’s unrealistic. Further, because of the systems in which both practice their professions, they may be technically perfect and still have an undesirable outcome simply because of the errors of others, latent errors in the system, or other unanticipated events.

Changing the paradigm to one that is inclusive of this reality allows for and encourages a layering of team management skills over technical skills to facilitate further reduction of untoward outcomes. Strengthening the systems used by hospitals, physicians, nurses, and their teams is where most of the work needs to be done to improve patient safety and provide reliable care.”
Do you find that physicians are hesitant to adopt aviation safety techniques in medicine? If so, why the reluctance?

“Many physicians are indeed hesitant in the beginning. Logically, physicians should be skeptical of ‘new’ procedures and techniques and scrutinize these ideas and concepts on behalf of their patients. Once physicians understand the skills and techniques used in CRM and comprehend the tremendous impact they have had on the safety of high reliability organizations (like commercial aviation), they often find that the concepts are not so radical at all. In fact, the skills and behaviors advocated by LifeWings are simple-to-understand, common-sense techniques that require persistence and flexibility. The benefits of hardwiring these changes permanently into their systems far outweigh any concerns that CRM might just be another ‘flavor of the month’ effort.”

If an office-based physician can only adopt one aviation-based patient safety technique, what should it be?

“It should really be a change in outlook to expect error. Dr. James Reason argues in his work that the physicians with the best outcomes were not necessarily the ones with the greatest skill. They were the ones who expected adverse events and put into place systems to trap and mitigate the impact of error. Physicians should look at their practice and evaluate how things could potentially go wrong, especially if the existing system is dependent upon one person being error free. Target those areas with focused solutions and systems to prevent an unwanted outcome. A couple of examples:

1. Implement a ‘hot box’ that houses a copy of all lab results that are critical and timed (24 hours), which are reviewed at a given time of day to ensure that results were received when expected. Tie that review to a fixed event that happens without fail every day.

2. Educate the patient (or parent in the case of children) on what you expect them to do to help the rest of the health care team deliver the optimum care/cure to the patient. In other words, engage the patient as a critical part of the health care team and encourage them to ask questions when something does not seem right.”

Steven Montague is Vice President for LifeWings Partners. With more than 26 years in aviation, Mr. Montague is an experienced facilitator of CRM-based patient safety programs. He has provided program implementation for several organizations including Texas Spine and Joint Hospital, University of Texas Medical Branch, Vanderbilt University Medical Center, Vassar Brothers Medical Center, and the University of California, Los Angeles.

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Failure to conduct a proper exam

by Barbara Rose and Laura Brockway

Presentation
In April 2001, an 87-year-old woman came to see her internal medicine physician (Internist A) with a chief complaint of osteoporosis and depression. The patient’s family also reported that she was experiencing some type of “inappropriate” behavior, but nothing specific was noted in the medical record. The patient’s history included osteoporosis, anemia, peripheral vascular disease, and osteoarthritis.

Physician action
Internist A diagnosed the patient with psychosis based on her report of sleep disturbance, hallucinations, and illusions. He attributed the findings to normal aging and did not order any tests.

Over the next several months, it was felt the patient’s “psychosis” was improving. In August 2001, Internist A charted a normal neurological exam and asked her to return in two years.

In February 2002, the patient came to the office for complaints from her family that she was “really aggressive.” A physician’s assistant (PA) examined the patient, and noted the exam to be unremarkable. His impression was anemia, osteoporosis, and psychosis. He increased the patient’s Risperdal to 1 mg at bedtime. The PA saw the patient again in March. She complained that her ears were clogged. The PA documented no abnormalities and his impression was anemia, osteoporosis, and psychosis. He did check the patient for earwax, but found none.

In June 2002, another internal medicine physician (Internist B) saw the patient for her osteoporosis. He documented a full neurological exam, which was within normal limits. There were not significant findings from this visit. The patient refused a Pap smear, mammogram, and colonoscopy.

The patient returned on September 16 with complaints of feeling tired, trouble walking, confusion, depression, and a red patch on her skin. Her memory was worse, but she had no deficits. Internist A noted that she was not unbalanced. He scheduled her for a physical exam in ten days, and prescribed Zyprexa and Exelon. Internist A also told the patient to go to the emergency department (ED) if she had any further problems in the interim.

Two days after this visit, the patient went to a local ED with her daughter reporting a history of advanced, severe dementia, organic brain syndrome, and osteoporosis. The emergency medicine physician noted that the patient’s daughter indicated the patient had progressively worsening mental function, worsening cognitive abilities, inability to eat or drink, and weakness in her legs. A CT scan of the head showed hydrocephalus and cerebellar infarct, but not a bleed. It did not show a mass. Because the hospital did not have a neurologist available, the patient was transferred to another hospital. The patient’s discharge diagnosis was cerebellar stroke, dementia, organic brain syndrome, and osteoporosis.

Another CT scan was performed at the second hospital. It revealed a mass at the right cerebellopontine angle of low attenuation and low attenuation in the inferior right cerebellar hemisphere, perhaps representing a chronic infarct. An MRI revealed an extra-axial mass lesion in the anterior aspect of the right side of the posterior fossa located in the right cerebellopontine angle cistern and displacing pons in lower mid-brain towards the left, compressing both portions of the brainstem. At the time of her physical exam, the patient was unresponsive except to painful stimuli. Laboratory studies did not reveal any significant changes, and her EKG did not show acute changes. The patient’s daughter confirmed the patient’s status as “do not resuscitate.”

The patient was admitted and her cognitive status and mental function declined progressively. She continued on a downward spiral during this hospitalization, requiring a feeding tube. She died on September 25 with the immediate cause of death listed as a brain tumor with underlying hypertension.

Allegations
Lawsuits were filed against Internist A and B. The plaintiffs alleged that the defendants negligently diagnosed the patient as having dementia when she was actually suffering from a brain tumor. Specifically, the defendants failed to order proper tests and conduct proper exams; failed to call in consultants; and failed to recognize and treat the onset of complications. The patient’s deteriorating condition should have prompted the defendants to order additional tests.

Legal implications
The plaintiff’s internal medicine expert stated that Internist A did not take a thorough history, perform a careful physical exam, or obtain laboratory studies. Therefore, he failed to obtain enough information to make a diagnosis of psychosis. A CT scan, an MRI of the brain, or a lumbar puncture were indicated if lab studies failed to find a definite cause of the “psychosis.” This physician also believed the patient’s “psychosis” was actually a brain tumor that had been present for many years, and April 2001 was the date when the patient’s hydrocephalus was beginning to manifest itself.

Regarding Internist B, the plaintiff’s expert stated that he had a duty to review the patient’s chart and determine if she had been correctly diagnosed before he continued.

continued on page 16
Wrong kidney removed

by Barbara Rose and Laura Brockway

Presentation

A 79-year-old man came to a urologist for evaluation of a left renal mass. The mass was 3 cm and had been found on ultrasound two weeks earlier. The patient’s history included COPD, hypertension, coronary artery disease, heart surgery, angioplasty, pacemaker placement, peripheral vascular disease, and diabetes mellitus. He also reported that his father had a history of kidney disease. Routine medications included a blood thinner.

Physician action

The urologist ordered lab work and a CT of the abdomen/pelvis. He asked the patient to return in two weeks.

The patient was seen again on January 18. The CT scan showed a 3- to 4-cm left renal mass with no metastases. The urologist suggested laparoscopic removal of the left kidney. He discussed the procedure — and its risks — with the patient and noted that all his questions were answered. The patient consented to the procedure.

The surgery was initially scheduled for March 22. However, when the patient was being evaluated before surgery, it was discovered that he had stopped his reflux medication instead of his blood thinner. The surgery was rescheduled for March 29.

The patient came to the hospital on March 29. The preoperative schedule listed left nephrectomy. A nurse had the patient sign the consent form for a left nephrectomy. The urologist met with the patient, and told him that he was performing a right nephrectomy. He documented in the medical record that he was performing a right nephrectomy. A second nurse heard the urologist tell the patient about the right nephrectomy. She changed the consent form to right nephrectomy and had the patient initial it. When the patient’s wife found out that they had marked her husband for the right, she challenged the nurses.

The urologist reviewed the CT scan and confirmed the surgery was for the right side. The anesthesiologist had left nephrectomy listed on his preoperative chart. But when he saw that the urologist had noted the right side in the medical record, that the patient had been marked as right, and asked the patient to confirm the right side, the anesthesiologist said he confirmed that the surgery was on the right.

After the patient had been brought into the operating room (OR) and put under anesthesia, the nurse made a comment that it was strange that her preoperative note said left side, but the patient was marked for a right nephrectomy. The anesthesiologist then told the nurse to get the urologist and have him confirm the surgery. When the urologist came into the OR, he went to the foot of the bed and reviewed the CT scan. He said that the surgery was to be done on the right side and for everyone to consider that to be the official “time out.” The surgery proceeded and the patient’s right kidney was removed. The procedure went well, and he was discharged on March 31.

When the patient came for his initial postoperative visit, the pathology report showed there was no tumor in the kidney. The urologist said that he would find out what happened. He went to the radiologist’s office, reviewed the films, and discovered that he had removed the wrong kidney. The urologist told this to the patient and his wife on a subsequent visit.

The patient is currently being followed by a nephrologist. He is monitoring the kidney function and size of the tumor and has discussed several options. The options include continuing to monitor the kidney, removing the tumor and leaving in the remaining portion of the kidney, or removing the kidney and placing the patient on dialysis. The patient will never qualify for a kidney transplant because of his medical history and his age.

Allegations

Lawsuits were filed against the urologist, the assistant surgeon, the anesthesiologist, and the hospital alleging that the wrong kidney was removed during surgery. It was alleged that the defendants did not follow procedure to confirm the correct organ prior to removal.

Legal implications

The urologist offered a possible explanation for removing the wrong kidney — he must have had the wrong CT scan in the OR. He said that he brings the films with him from the office and usually puts them up himself. The OR staff could have removed the film for this patient and replaced it with another patient’s film and the urologist did not know it. On March 22, he had the preoperative discussion with the patient but the surgery did not take place because the patient did not discontinue his blood thinner. The surgery occurred on March 29, a week after the urologist’s preoperative visit with the patient. This mix-up with the CT scan might not have happened if the surgery had gone forward on March 22. The urologist stated it was also possible that he placed the patient’s films on the view box backwards.

Expert reviews determined that the hospital shared responsibility for this outcome because staff did not confirm with the office chart the correct surgical site.

Disposition

This case was settled on behalf of the urologist and the hospital. The cases against the assistant surgeon and anesthesiologist were dropped.

Risk management considerations

In spite of all the protocols to verify the correct surgical procedure, wrong site surgeries continue to occur. In this case, when the wife challenged the site, the nurses and anesthesiologist acknowledged a left nephrectomy on the preoperative schedule, one would hope everything would be “suspended” until the medical record was reviewed and the final report of the CT scan read. Then the “official time out” for verification of the procedure would be valid.

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continued from page 14

her medications. According to this expert, “it should have been obvious” to Internist B that Internist A did not obtain enough information to make a diagnosis of psychosis. Internist B should have referred the patient to a neurologist.

Defense experts who reviewed this case were supportive of Internist A and B. One internal medicine physician stated that it was not the standard of care for Internist A or his PA to order imaging studies, a lumbar puncture, or other labs when managing the patient’s care in 2001 and 2002. Additionally, the patient did not exhibit symptoms that would have led the physicians or the PA to suspect a tumor.

Causation became hotly debated among the experts who reviewed this case. Defense experts stated that it was unlikely that an earlier diagnosis would have made a difference in the patient’s outcome. Had the tumor been discovered earlier, it was unlikely that a neurosurgeon would agree to remove the tumor because of the patient’s age. The plaintiff’s neurosurgeon expert stated that the patient was not a candidate for surgical removal of the lesion. However, she was a good candidate — before September 19 — for a debulking procedure. A debulking procedure done anytime before the development of severe symptoms would have involved minimal risk and would have given her “a number of meaningful years.”

Documentation was a weakness in this case. The record-keeping by Internist A and the PA were described as “less than optimal.” Additionally, the PA saw the patient for several key visits. While there was expert support for the PA’s actions, it was felt that a jury might have believed the patient’s complaints were beyond what a PA should have been handling. Internist A had no written protocol or guidelines in his office for the PA, and he acknowledged that he did not know that he needed to do so. This called into question Internist A’s supervision of the PA.

Disposition
Given the documentation issues and the fact that there were no protocols in place for the PA, this case was settled on behalf of Internist A. The outcome of the case against Internist B is unknown.

Risk management considerations
Comprehensive and contemporaneous documentation of all patient encounters is not only a practical protocol, it is required under the guidelines of the Texas Medical Board. The passage of time and reliance on memory may diminish the chance of a successful defense of a physician. The record is expected to objectively and accurately record a physician’s assessment, findings, diagnoses, and decisions that substantiate the plan of care.

The Texas Medical Board, the Texas Physician Assistant Board, and the Texas Occupations Code establish guidelines for the delegation of health care tasks to qualified non-physicians providing services to patients. These include the scope of standing delegation orders for a physician assistant. This information is available at www.tmb.state.tx.us/rules/rules/193.php.

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