Combating physician stress and burnout

by Barbara Rose

“Self-love my liege is not so vile a sin/As self-neglecting.” (King Henry V, Act 2, scene 4)

In today’s stress-filled world, with no exception or reprieve for physicians, these lines serve as a reminder that physicians who neglect their own health may be perceived as careless with the health of their patients. Self-care is unlikely to be part of physicians’ training and no doubt ranks low on a list of priorities. Many physicians do not have a personal physician for their own care. From this fact it is a short leap to the premise that a stressed out physician may struggle to build effective physician-patient relationships, make more medical errors, and be at risk for malpractice lawsuits.

We all experience stress in our lives. How we deal with it depends on many factors — age, maturity, work, relationships, and approach to life — to name a few. One study of 130 physicians revealed that the use of “wellness-promotion practices is associated with increased psychological well-being among physicians.” From the analysis of the survey, five wellness-promotion elements were identified and included: relationships, self-care, work, spirituality, and approaches to life.

Among the physicians who reported use of any of these elements, there was a trend toward increased psychological well-being. When use of these five practice categories was compared, the approach-to-life practice was linked to significantly higher levels of psychological well-being. “These wellness-promotion practices included general philosophical outlooks such as being positive, focusing on success, maintaining a balance in life, and specific strategies on implementing such approaches.”

Identifying burnout

The characteristics of burnout include fatigue, inability to concentrate, anxiety, irritability, insomnia, depression and, at times, increased use of alcohol or drugs. The most distinct characteristic of burnout is likely to be a loss of interest in one’s work and/or personal life. Some studies suggest that burned out physicians have more trouble relating to patients, and the quality of care they provide may suffer.”

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According to stress management experts, the risks of today’s physicians experiencing burnout are greater than ever as they deal with information overload, lower reimbursement, insurance issues, patients with unrealistic expectations, and the increasing number of children and adults without health insurance. Past generations of physicians were taught to keep going when things got tough. That continues to be the ethos for some physicians.  

Compassion fatigue
Some physicians may experience a form of burnout known as compassion fatigue, “a deep physical, emotional and spiritual exhaustion accompanied by acute emotional pain.”  

Physicians with burnout may adapt to their stressors by becoming less empathetic and more withdrawn. Physicians with compassion fatigue “continue to give themselves fully to their patients, finding it difficult to maintain a healthy balance of empathy and objectivity.”  

In an article published in Family Practice Management, the authors propose “to prevent or recover from compassion fatigue, take time for self-reflection, identify what’s important and live in a way that reflects it. To sustain yourself at work, develop principles of practice — guidelines of personal integrity that articulate the parameters of your personal values. Commit to live and work within these principles.”  

Compassion fatigue or burnout does not have to result in a career-ending event. Options exist for physicians who may be burned out and need help. The Texas Medical Association’s Committee on Physician Health and Rehabilitation is dedicated to the promotion of physician health and well-being. For more information, please visit the committee’s web site at http://www.texmed.org/Template.aspx?id=4751.

Warning signs
Assess the balance in your life — all aspects — emotional, social, intellectual, spiritual, occupational, financial, and physical. Achieving balance provides resilience and energy to deal with stress, avoid burnout, and extract the greatest meaning and joy from everything life has to offer. The warning signs of stress and burnout include:

- emotional and physical exhaustion;
- physical symptoms such as headaches, chest pains, depression, sleepiness, digestive problems;
- anger, anxious or irritable behavior toward others;
- outbursts of temper;
- inability to take on additional tasks;
- feelings of helplessness and loss of control;
- persistent thoughts of quitting work;
- sarcasm, negativism, and cynicism at work or home;
- feeling guilty when at rest or play; and
- placing blame on others.  

How to overcome burnout:
- Identify stressors and focus on what you can control. Learn to cope with things you cannot control.
- Slow down and leave your work at the office.
- Make time for yourself and your family.
- Prioritize what is important and urgent.
- Vary your workload and know your limit.
- Exercise, eat right, and get enough sleep.
- Connect with those around you.
- Find ways to have fun each day.  

Physicians who have “hit the wall” after ignoring stress that has progressed to burnout have coped in a variety of ways. These include leaving medicine abruptly, taking early retirement, making a career change within medicine if options are available, and taking time off with and without family to reflect and recover. This writer met a cardiologist several years ago who, at the pinnacle of his career in medicine, was retiring and had enrolled in a cooking school in Europe.

For the burned out physician who wants and needs to continue his or her career, support and options for recovery are available. Find a solution uniquely meaningful for yourself and take action. For some, this could mean participating in a retreat or joining a physician support group. For others, the solution may be taking a long-deferred vacation or a sabbatical to reconnoiter and recover.

“Dealing with the demands of medicine by becoming cynical only serves to diminish creativity and the meaning of medicine . . . physicians will be better able to cope with the daily pressure of practicing medicine if they acknowledge and care for their physical, emotional and spiritual needs. Physician support groups and individual therapy are not for impaired physicians only. They are a safe place for healthy, stressed physicians to work through professional and personal problems.”

While discussing stress and burnout with a physician who has practiced many years, this physician’s shared experience and insights were meaningful. To cope with the heightened demands of the medical profession, he described a “major decision to focus on the positive attributes of medicine,” and why he “went into medicine and what has sustained him all these years.” He renewed his commitment to “always put the patients’ interests first.” To him, medicine is part of his “whole being rather than simply as a segregated part of life” to be turned on and off in his practice.

A Minnesota physician who spoke of his own battle with depression told American Medical News, “There is a presumption that, unless you are invincible, you are a less-than-optimal physician, which is simply not true.”  

Men and women with the same human weaknesses present in all of us apply to medical schools. As medical students, residents, fellows, and practicing physicians, our humanness — with all its incumbent foibles — remains. The difference in response to stress and avoidance of burnout is influenced by all facets of life. Recognizing stress and burnout, reflecting, re-evaluating goals and values, taking action to intervene, and finding balance is the key. We all have choices, and making choices should include acknowledging our needs. Maintain flexibility in life. Physician, do no harm and heal thyself!

Sources

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TMLT announces rate reductions, declares 22% dividend

The TMLT Governing Board has approved an unprecedented third straight rate reduction and dividend for TMLT policyholders. The Board has approved a 6.5% rate reduction for all medical specialties and classes effective January 1, 2008. In addition, all current TMLT policyholders renewing their policies in 2008 will receive a dividend equal to 22% of their expiring premium. The total dividend declared is approximately $35 million. The dividend will be applied at policy renewal.

TMLT has reduced rates five consecutive years since the passage of House Bill 4 and Proposition 12 in 2003: 12% in 2004; 5% in 2005; 5% in 2006; 7.5% in 2007; and 6.5% in 2008. The net effect of these cumulative rate reductions amounts to a 31% reduction from 2003 rates and approximately $200 million of premium savings.

The dividend for 2008 represents the third consecutive year TMLT has declared a policyholder dividend. By the end of 2008, renewing policyholders will have received dividends amounting to approximately $75 million. Since the passage of Proposition 12 and medical liability reform of 2003, TMLT policyholders will have realized cumulative savings of approximately $275 million from rate reductions and dividends.

Effective medical liability reform has reduced claims intake and associated legal expenses. Improved Trust earnings have strengthened TMLT’s financial position making these rate reductions and dividends possible. There is no guarantee that an ever-changing business climate will ensure future rate reductions or dividends; however, TMLT continues to work diligently to protect 2003 reforms in an effort to keep premiums as low as possible. Rate changes and dividend considerations are determined annually by the TMLT Governing Board, executive management, and financial consultants to the Trust.

TMLT offers fall CME program

In October, the TMLT Risk Management Department will offer the Fall seminar series “Soaring Over the Safety and Quality Chasm: Using Teamwork and Communication to Reduce Medical Liability Risk and Improve Performance.” The seminar will discuss aviation-based safety programs and the similarities between health care and aviation. The seminar also includes team-building training and a discussion of cross-checking and communication in health care.

The seminars are led by Steven B. Montague, a senior project lead at LifeWings. Mr. Montague is an experienced facilitator of aviation-based patient safety programs. He has provided program implementation for Vanderbilt University Medical Center, Missouri University Health Center, Vassar Brothers Medical Center, Texas Spine and Joint Hospital, University of Texas Medical Branch, University of Nebraska Medical Center, and several others.

Upon completion of this program, participants should be able to:

- state the effect of team training on aviation accident and incident rates;
- describe the similarities between health care and aviation;
- explain the benefit of teamwork to the health care team;
- describe the process of balancing the leader’s authority with the team’s participation;
- state the one communication technique with a proven record of decreasing communication based errors; and
- define the process of “cross-checking” performance.

TMLT 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 3 AMA PRA Category 1 Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

TMLT has designated this course for 1 hour of education in medical ethics and/or professional responsibility. TMLT policyholders who complete this program will earn a 3% discount (maximum $1,000) that will be applied to their next eligible policy period. Course dates and locations are:

**Tuesday, October 2, 2007**
Austin Renaissance Hotel
9721 Arboretum Blvd, Austin

**Thursday, October 4, 2007**
Fort Worth Renaissance Worthington Hotel
200 Main Street, Fort Worth

**Tuesday, October 9, 2007**
San Antonio Marriott NW
3233 NW Loop 410, San Antonio

**Thursday, October 11, 2007**
Dallas Renaissance Hotel
2222 Stemmons Freeway, Dallas

**Thursday, October 18, 2007**
**Thursday, October 25, 2007**
Houston Marriott Medical Center Hotel
6580 Fannin Street, Houston

The dinner and program will take place from 6:30-9:30 p.m. Registration begins at 6 p.m. The registration fee is $25 for TMLT policyholders and $35 for non-TMLT policyholders.

To register, please visit www.tmlt.org or contact Rebecca Henson at rebecca-henson@tmlt.org, or 800-580-8658 ext. 5912. Please register no later than one week before each seminar.
The TMLT Memorial Scholarships were created to recognize students who are interested in finding creative ways to enhance patient safety. Each year, the $5,000 scholarships are awarded to one student at each Texas medical school that participates in the competition. Applicants were asked to communicate their ideas about patient safety in a short essay. Recipients were chosen based on their written essay and financial need.

In 2007, we received 41 applications from students at 7 Texas medical schools. We are proud to introduce the recipients of the 2007 TMLT Memorial Scholarships:

John Chiara is a fourth-year medical student at Texas Tech University Health Science Center School of Medicine. (Mr. Chiara also won the scholarship from Texas Tech in 2006.)

Paul Chin is a fourth-year medical student at the University of Texas Southwestern Medical School.

Julie Cummings is a fourth-year medical student at the University of Texas Medical Branch at Galveston.

Stanford T. Israelsen is a fourth-year medical student at Baylor College of Medicine.

Jason R. Pearce is a fourth-year medical student at University of Texas Medical School at Houston.

Eric South is a third-year medical student at the University of North Texas Health Science Center’s Texas College of Osteopathic Medicine.

John Wilkinson is a fourth-year medical student at Texas A&M University System Health Science Center College of Medicine.

For the essay assignment, students were asked to write risk management considerations for a closed claim study provided by TMLT. The case study and recipients’ essays follow.

The case study – failure to evaluate and test

Presentation and physician action

A 63-year-old man came to a new family physician primarily for the treatment of hypertension. The patient continued seeing this physician for routine medical care over the next four years. Documentation in the medical record for these visits was extremely limited. Vital signs were not documented for more than 30 visits with this patient. Though the physician was treating the patient for hypertension, there is only one recorded blood pressure measurement.

In April 2003, the patient came to the physician with an infected mole of the left upper arm. The physician prescribed Tetracycline with a note: “excise or hypercure later.” This is the first documented reference to an upper arm mole. The patient later testified that he had shown the mole to the doctor in September 2001 when it started changing colors. He also testified that he showed the family physician the mole in September 2002, and that the physician told him it was nothing to worry about. The physician testified he was not made aware of the mole until April 2003.

The patient returned in May 2003. The left arm mole was still infected. The physician prescribed Keflex. After little improvement with two rounds of different antibiotics, the patient was referred to a general surgeon for excision of the mole.

A general surgeon saw the patient. He told the surgeon that the mole had been gradually increasing in size for several months, becoming more irritated, brittle, and had been bleeding. Examination revealed a two-centimeter raised ulcerated lesion consistent with a basal cell carcinoma versus irritated keratosis. The lesion was excised and sent to a lab. The pathologist’s initial opinion was poorly differentiated carcinoma, likely squamous. The slides were sent to another lab for subsequent review. Further evaluation revealed a stage IIIA malignant melanoma, differentiated, completely, but narrowly excised.

Two months after the excision, the patient returned to the general surgeon. The surgeon believed the patient would need a wide excision and sentinel node biopsy. A CT scan of the head, chest, and abdomen revealed a tiny nodule on the right middle lobe of the lung. MRI of the brain did not show any significant findings. A PET scan revealed malignant disease of the lymph nodes in the left axilla.

The patient returned to the general surgeon to undergo a wide excision and left axillary node dissection with skin grafting at the excision site. Pathology revealed that two of the 22 lymph nodes were positive for metastatic neoplasm consistent with metastatic malignant melanoma.

Over the next several months the patient underwent chemotherapy treatment for a new mass in the right middle lobe of the lung. The patient exhibited good response from the chemotherapy and a CT of the abdomen and pelvis showed the lungs free of infiltrates or masses. One year after the original excision the patient showed no evidence of disease progression.

Allegations

A lawsuit was filed against the family physician, alleging that he failed to properly evaluate, test, and diagnose the patient’s mole and refer him to a dermatologist for evaluation. The plaintiffs questioned whether it was within the standard of care for the physician to prescribe antibiotic treatment for what he thought was a squamous cell carcinoma, rather than referring the patient to a surgeon for biopsy.

Legal implications

The plaintiffs were able to locate an expert who testified that the malignant melanoma went undiagnosed for 31 months and subsequently decreased the patient’s life expectancy.

Physician consultants for the defense were critical of the family physician’s poor documentation. Most of the entries made no reference to a reason for the visit, physical exam and findings, or a plan of care.
The physician did document the presence of the upper arm mole in April 2003. However, the lesion was first documented two years after the patient claimed he first brought it to the physician’s attention.

Another family physician consultant pointed out that the defendant’s documentation was poor and often illegible. However, the documentation indicated that from the time the mole was first documented in the chart, there was reasonable treatment. Additionally, besides the poor documentation, it appeared that the defendant practiced within the standard of care with regular office visits, appropriate prescriptions, and lab work ordered at each visit.

Defense consultants also pointed out that the mole was felt to be either a basal cell carcinoma or an irritated keratosis; both of these are easily curable. On exam, the mole did not look like a melanoma, supporting the physician’s slow timeframe for biopsy. The pathology report after excision was also confusing, suggesting an atypical lesion.

Disposition
A significant weakness for the defense was the conflict between the patient and the physician about when the upper arm mole was mentioned. It was believed that a jury might conclude that an earlier diagnosis was possible. This factor, along with the inadequacy of the physician’s documentation, led to the decision to settle this case on behalf of the defendant.

Risk management considerations by John Wilkinson

Thirty visits to a primary care doctor, two ineffective antibiotics, one bleeding mole . . . zero documentation of possible skin cancer.

Melanoma is a frustrating disease to diagnose and treat. With appropriate precautions and proper record keeping, however, this type of malignancy can be caught before it spreads. With a personal history of over 10 excisional and shave biopsies, numerous lab reports, two re-excisions, and countless skin checks, I have learned first-hand about the screening process for melanoma. As I read this closed claim study, many alarms went off in my head. The patient is concerned. The mole is changing shape and bleeding. The infected appearance did not improve with antibiotics. But were these alarming symptoms also concerning to the patient’s practitioner? We do not know because the physician’s thoughts were not documented in detail.

When a person finds out that they have cancer, it is a traumatic experience. It may be one of the most difficult situations in their life. They feel frightened, alone, worried, frustrated, angry, depressed, and, likely, overwhelmed.

Understandably, a common question might be, “Was this preventable?”

In this case, we do not know if the patient’s cancer would have been avoided if it had been discussed, treated, and followed-up at an earlier stage. The central issue in this case is documentation. The following are steps that I would have taken to change the course of this patient’s care:

• Asked patient to complete a review of systems form — this would have included the patient’s chief complaint and any worrisome symptoms for discussion during the visit.
• Taken a picture — digital photography is an inexpensive and easy medium to use which, in this setting, would have given clear understanding of what the lesion looked like on initial presentation and how it changed over time.
• Completed an electronic medical record — checkbox-based entries can quickly document which parts of a history and physical are completed during a problem-focused clinic visit. This EMR could have been used and supplemented with a dictation-based system to record the assessment and plan.
• Distributed handouts on skin cancer signs and symptoms
• Personally called the patient to follow up after the clinic visit
• Hired a physician extender — this person would have assisted with follow-up for this patient’s care.
• Organized a meeting — a meeting would allow local doctors to share best practices on how to manage a busy clinic schedule while completing necessary documentation.

Although it is sometimes difficult to find time in a busy practice, documentation of a doctor’s actions not only records details of an office visit but, more importantly, provides the treating physician with a plan of action for subsequent visits. It may be debatable whether the suggestions listed above would have made a difference in the patient’s outcome. Ultimately, however, we have an obligation to our patients to fully document clinic visits so that we can take their care and our overall profession to a higher level.
Risk management considerations
by Paul Chin

Given the current view that primary care physicians are directors and coordinators of care and subsequent unrealistic patient expectations for that care, any failure or delay in evaluation, diagnosis, and treatment can be grounds for litigation. Thus, implementation of several proactive techniques can ensure the achievement of standard of care and reduction of risk and liability.

First and foremost, the outcome of this claim demonstrates the absolute necessity of proper documentation. Did this physician fail to document the two previous references to a mole, or did this patient fabricate the two previous references? Given over two dozen omissions of vital signs in this hypertensive patient’s medical record, how difficult do you think it would have been for a plaintiff’s attorney to persuade a jury that this physician clearly did not document the two previous references to this mole? Although some feel that documentation has become a bane of modern medicine, always remember that proper documentation is protection. It is protection from the mind’s tendency to forget and distort the past, and it is protection from the 20/20 hindsight of expert witnesses.

Furthermore, it behooves all physicians to act quickly if a medical decision is out of their realm of expertise. In these situations quick referrals to experts can avoid potential conflicts such as the one in this claim. This patient would most likely have benefited from an earlier referral to a dermatologist to evaluate his condition. Nevertheless, in a common scenario such as this involving a skin lesion, records such as photographs are as the saying goes “worth a thousand words” and should be kept in a patient’s medical record.

Finally, it is vital to assess the health literacy of patients including their understanding of their medical conditions and treatments plans. Implementation of these simple techniques will help guarantee excellent patient care, safety, and confidence.

Risk management considerations by Eric South

In my medical training, I have been taught that “if it isn’t written in the chart then it wasn’t done.” The patient in the case visited the physician 30 times yet there was only one instance of vitals documented. To diagnose hypertension, the minimum is two instances observed over a period of time. While I hope someone took the patient’s blood pressure every visit, without it documented, others must assume that it was not performed. In addition, the physician cannot chart the effectiveness of the treatment plan for hypertension without documented blood pressure. This is an unacceptable level of documentation that leaves the physician exposed legally and prevents proper care.

Regarding the mole on the patient’s arm that was found later to be a malignant melanoma, the past medical records give the impression that the doctor was sloppy and careless whether or not this was true. As a family physician he was trained and able to treat skin lesions such as this or to refer if the situation is more complex. Based on the fact that the skin lesion was atypical this situation may have been handled correctly from April 2003 onward. When the lesion was unresponsive to antibiotic treatment, he properly referred the patient to the surgeon for excision. Questions arise from the documentation to “excise or hypercetate later.” If the lesion needed to be excised, he should have made arrangements to do so. Writing in the chart “reevaluate later” would have been more acceptable if he felt the lesion was likely not skin cancer. This raises the question presented in the case of whether antibiotic treatment was the standard of care for suspected skin cancer. This calls the physician’s practice into question in addition to his documentation.

The major problem was whether or not the physician was aware of this skin lesion as of September 2001. If he was aware in 2001 and did nothing, the physician also needs to be referred to the state medical board in addition to the legal proceedings. The physician in question has allowed himself to be set up for disaster. His failure to thoroughly document details from patient visits leaves him at the mercy of the legal system. The case in question comes down to the patient’s word against the physician’s medical records. Based on past medical records that were reviewed by others, the notes were poorly written, but the physician did practice within the standard of care by ordering appropriate tests, etc. Had the physician properly documented everything from the visits and set a high standard of doing so, this case would have no strength. It is unknown whether or not this lesion was brought to the physician’s attention much earlier so the issue that needs to be addressed is the level and quality of charting patient visits. Better documentation is necessary to provide the highest quality of care for other patients and allow the physician to defend himself in future legal situations.

Risk management considerations by Jason R. Pearce

In an era of increasing litigation, it has become the physician’s responsibility to not only treat patients, but to also protect against legal culpability at the same time. In my own experience and from talking to other physicians the two most commonly practiced methods of protecting oneself from being sued are good patient-doctor communication and proper documentation. In this case the physician appears to be at fault with both these principles.

The particular difficulty in this case seems to be in trying to prove that something did not happen, in particular that the physician had not seen the patient’s skin lesion until April of 2003. The physician’s best argument is that the mole wasn’t seen until April, and at that point he then took the appropriate actions. If the physician was to have shown a history of both consistent and thorough documentation of each patient encounter, it becomes more difficult to argue that the physician somehow failed to mention this skin lesion, but was then thorough in every other aspect of his documentation. There are several techniques the physician could have employed to help in this situation. First, the doctor should have made a comment at the end of each note that the patient had the chance to ask all of his questions and that before exiting the patient understood the plan until his next visit. This would have been more evidence that the doctor went out of his way to allow the patient to mention any concerns about the skin lesion. Next, if the doctor would have had his nurse/staff ask the patient what the
Risk management considerations by Julie Cummings

I am overbooked in clinic today and need to be home by 5:30 to take my son to his soccer tournament. My next patient is Mr. Rogers, one of my regulars. I have been following him for the past year for hypertension. I go into his room and record his vitals in the chart. Just as I expected, his blood pressure is 128/76. He has no symptoms, and just needs refills of his medications. I look through his chart, noticing his blood pressure has been well controlled at all previous visits and he is current on labs. I also notice that three months ago he was concerned about a mole that was changing colors on his left upper arm. I examine Mr. Rogers and measure his mole at 6 mm x 4 mm. At his last visit the size of the mole was recorded at 4 mm x 2 mm. I inform Mr. Rogers that his mole has changed and needs further evaluation. I give him the options of performing a biopsy or referring him to a dermatologist. He says “I am more comfortable with you than a stranger.” I am proud that he has confidence in me, but I am running out of time. I scheduled a follow-up appointment for him next week to biopsy the mole.

The next week, I explain to Mr. Rogers that clinically the mole looks like basal cell carcinoma, which is a type of skin cancer that rarely spreads and has a very high cure rate. I also tell him about squamous cell carcinoma, actinic keratosis, and melanoma. I tell him that pathology is necessary for diagnosis.

The pathology reveals melanoma in situ. I call Mr. Rogers and schedule a follow-up appointment to discuss the results. At the appointment, I tell him the lesion was not what I thought originally. I ask him if he would like to know the results and he agrees. I tell him he has melanoma localized to the skin. He says, “that’s the bad kind we talked about, right.” I tell him it is and I am sorry to be giving him such bad news, but it is still localized to the skin, and it is good that we caught it in such an early stage. I ask him if he needs to call anyone for support or if he needs help telling his wife. He says he is okay. I refer him to a surgeon and his melanoma is removed with negative margins.

Five years later, I see Mr. Rogers at one of his regular clinic visits. I reflect back on how accurate evaluation and documentation prevented Mr. Rogers from having a higher staged melanoma. I recall how busy my clinic was that day and am relieved that I always kept precise documentation and take time to review it. I have the responsibility to be a good physician that spends time to obtain a full health history, documents it properly, educates the patient, and discusses treatment options. By practicing responsible medicine I am practicing defendable medicine.

reason for the office visit was and then documented it in the chart, it would have been more difficult to argue that he actually mentioned his mole during the visit, yet no one wrote it in the chart. Also the doctor could have drawn a picture of the lesion when it was first mentioned noting the location and size of the lesion; if for no other reason than to monitor any change over time, but at the same time to illustrate a start point to visualization and treatment of the mole. Another technique that may have been very helpful would be to have his existing patients undergo a full physical exam every 1-2 years. This would have most likely revealed this skin finding or any other problems that had gone unnoticed by the patient or doctor. With this exam documented in the chart it would provide more evidence of the doctor’s overall quality of care.

The other concern is appropriate communication between the two parties. There appears to be confusion about why the doctor was using antibiotics for a possible malignancy. The patient should have been told why he was being given antibiotics and the physician’s differential diagnosis. There isn’t any reason not to tell the patient if the physician has concerns about malignancy.

Unfortunately, for this physician it didn’t matter how well the patient had been treated. With such poor documentation it became impossible to prove the quality of care given, thus leaving this doctor in the powerless position of he said, she said.
Calculating the costs
the risks and rewards of ancillary services

Course author
Eldon Volk is a risk management representative at TMLT.

Disclosure
Eldon Volk 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 October

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

1. conduct a basic review to determine if adding an ancillary service will benefit the practice;
2. describe the common business principles supporting the addition of an ancillary service;
3. discuss regulations affecting the addition of an ancillary service; and
4. implement strategies to reduce the risks associated with an ancillary service.
Calculating the costs to add to a medical practice should not be
considered a task to be taken lightly. Physicians contemplating the addition of ancillary medical services must overcome, and risk reduction efforts to
be considered as well. The costs can be significant, and the construction required to accommodate the new service may benefit from the addition of in-house laboratory services. Many patient populations may benefit from the addition of x-ray services. This could include a younger patient base where there may be a need to rule out fracture or an elderly base where chest x-rays are often needed. Other patient populations may be interested in cosmetic services such as Botox injections. After reviewing the general characteristics of the patient population, it is important to systematically determine the needs and interests of the patients.

To determine the needs of patients, a thorough review of patient data from previous visits should be conducted. Reviewing the patients’ chief complaints and the common diagnostic tests ordered can be valuable in deciding which ancillary services to offer. For practices that use electronic health records or practice management/billing software, it can be easy to determine the common needs of the patients. Query the electronic health record to find the total number of each specific diagnostic test ordered in facilities outside the practice during the previous year. If the practice does not use electronic records, a log of the tests ordered can be kept to determine test frequency. The diagnostic tests ordered with the greatest frequency may provide an opportunity for additional income if the tests were offered in-house in the future.

Determining the patient’s interests, in comparison, may be a little more difficult. Multiple methods can be used to establish which services patients would like to see added to the practice. Questioning patients during their visits, asking them to complete a written survey or web site survey, or conducting a telephone survey of patients are all options.

Consider asking patients:
- What would make receiving health care more convenient?
- Are there health care services you seek outside this office, which you would like to see offered here?
- Are you interested in receiving (a specific ancillary service) in our office?

These questions will help establish the specific desires of the patients. It may become apparent that patients find it inconvenient to travel to an off-site lab or that they are not interested in receiving cosmetic treatments in your office. Finding the answers to these questions will make adding the new service more successful.

Before adding a new service, it is also recommended that physicians contact their medical liability insurance carrier to discuss the service in detail. (TMLT policyholders should contact the underwriting department.)

The business behind the medicine

“Physicians still grapple with the professional perception that it is not proper for a physician to make money from the delivery of care in outpatient business ventures. If medicine is a physician’s ‘business,’ why shouldn’t a physician with an entrepreneurial orientation be allowed to design a plan for ancillary service delivery, execute it and make a profit?”

Expenses

Understanding the business requirements from the beginning is important for the success of the new venture. The easiest place to start is determining equipment costs. “A new DEXA machine, for example, costs an average of $35,000 . . . equipment to do stress tests runs $13,000 to $25,000, holter monitors about $7,000 and spirometers about $2,500 . . . an x-ray machine can range from $25,000 to $255,000 . . . ” The cost of equipment can vary widely depending on manufacturer, new or refurbished status, and desired functionality. All of these variables create the need to compare shop.

Also, consider leasing equipment instead of buying it. Leases may provide the opportunity to upgrade equipment regularly. In comparison, buying is long term. However, if a new piece of equipment is used less than anticipated, purchased equipment can be sold at any time to help recover costs whereas the leased equipment will continue to be an expense until the end of the lease term.

The procurement of equipment is only the first cost to consider. What is the cost of the space needed for the new service? Is construction required to accommodate the new service? These costs can be significant, and it is important to consider when determining the return on investment of the ancillary service.
“Experts suggest calculating the required square footage and allocating a percentage of rent. For example, if 100 square feet are used for an ancillary station in a 1,000 square foot office, 10% of the office rent should be allocated to the ancillary service.” Using this example allows one to compare the space’s current use and costs to its future use and costs. It is possible that the space that is now allocated for the new service may have been more profitable if left as an exam room.

Will new staff need to be hired? What type of training is required? Some services may require trained technical staff such as an x-ray technician or lab technician. Other services may be easily handled by current staff. At the very least, current staff and the physician will need training. Training costs will include the expense of the training, wages for time spent in training, and possible revenue lost during training.

Are there any other hidden costs? In addition to start-up costs, there will be costs to maintain the new equipment. Consider a service agreement with the equipment manufacturer or vendor. In addition to keeping the equipment in working order, such an agreement may indirectly help prevent medical malpractice lawsuits. Equipment that is not working properly could cause patient injury and may prompt a lawsuit.

Other hidden costs can include the incidentals required to operate the equipment. For example, if digital x-ray services are chosen, storage media will need to be increased and computer software may be needed. For traditional x-ray equipment, film and developing chemicals will be needed to process images. The addition of lab facilities will require the appropriate reagents and supplies to process samples.

Also, remember that other employees — not just the ones involved in managing the new service — will likely be affected. Accounting staff will incur a greater workload in having to bill for the new service. Front office staff will be tasked with establishing appointments and ensuring smooth patient flow given a greater volume of patients.

Revenues

Once expenses have been determined, the next step is to estimate the revenues the service will generate. Start by determining the top five payers in the practice. Contact these payers to ask the reimbursement rates for the specific CPT codes billed by the ancillary service. The Medicare reimbursement rates can also be used to help predict revenues. Remember that payers may have different pay schedules and may have different requirements for documentation that you must meet in order to bill for the ancillary service codes. Also, keep in mind that some payers require patients to seek laboratory or radiology services at specific facilities. Patients may not be willing to use the in-office service if it requires them to pay out-of-pocket for the service.

Calculate the total revenue to be generated by the new service using the expected patient volume numbers and multiplying this number by the estimated payment per service. Comparing the total estimated revenues to the estimated expenses will provide the total estimated profit or loss. If the calculation results in a loss, it is obvious that the practice should not proceed with this venture. But what if the result shows a marginal profit? If the results are marginal, the practice may decide the initial capital expenditure poses too great a risk to add the service at this time.

Most physicians enter a new business venture first with a caring attitude for their patients, hoping to provide the best care possible with the new service. Second is the hope to make a profit with the new service. However, without a profit . . . is it possible to provide the best care?

Rules and regulations

The addition of an ancillary service to a practice brings with it an array of rules and regulations to follow, and in some cases, a license to procure. However, if there is one sector that has become adept at navigating government regulations it is the health care sector. The following is a list of a few items that should be researched when considering adding a new ancillary service.

The Stark Law

The Physician Self-Referral Prohibition Statute, commonly referred to as the “Stark Law” is set forth in section 1877 of the Social Security Act. This statute prohibits physicians who refer Medicare or Medicaid patients for designated health services (DHS) to entities with which they or their immediate family members have a financial relationship. The list of designated health services is lengthy and includes services that physicians commonly conduct in their own offices, such as x-rays, MRIs, lab tests, and physical therapy.

The law includes exceptions. The most common is the “in-office ancillary service” exception, which allows physicians to refer designated health services to themselves when certain requirements are met. These include:

1. In-office ancillary services must be furnished personally by the referring physician, by a physician who is in the same group practice or by individuals who are “directly supervised” by one of those physicians.

2. In-office ancillary services must be provided in a building in which the referring physician or another member of the group practice furnishes physician services unrelated to DHS or in another building that is used by the group practice for the centralized provision of the group’s designated health services.

3. In-office ancillary services must be billed by the physician performing or supervising them, by a group practice of which that physician is a member under a billing number assigned to the group, or by an entity that is wholly owned by such physician or such group practice.

The Anti-Kickback statute

Physicians must also comply with the Anti-Kickback Statute, set forth in section 1128B of the Social Security Act. The law states “healthcare providers can’t ‘knowingly and willfully’ pay or receive anything of value in order to induce Medicare, Medicaid, or other federal healthcare program business.” The differences between the Stark Law and the Anti-Kickback law are:

1. The Stark statute pertains only to physician referrals under Medicare and Medicaid (‘physicians’ includes chiropractors and dentists but not midlevel providers, such as nurse practitioners and physician assistants); the anti-kickback statute is far broader and affects anyone engaging in business with a federal health care program.

2. The Stark Statute does not require bad intent (i.e., a tainted financial relationship violates the Stark law regardless of good intentions); the Anti-Kickback Statute requires intent, but it must be specific intent (i.e., not just intent that might merely be inferred from a pattern of behavior).

3. The Stark Statute exceptions define the boundaries of permissible behavior. The statute is a prohibition that can only be
The risks and rewards of ancillary services

overcome by complying explicitly with an exception. The Anti-Kickback ‘safe harbor’ regulations describe transactions that may tend to induce referrals but don’t necessarily violate the law. The safe harbor regulations state clearly that transactions that don’t meet a safe harbor don’t necessarily violate the statute; a prosecutor will evaluate the facts and circumstances to make that determination.

4. A Stark violation is punishable by civil money penalties; an anti-kickback violation is punishable by exclusion from federal health care programs, criminal penalties of up to $25,000 in fines or up to five years in jail (or both) and a $50,000 civil money penalty for each violation."

Since the exceptions to the Stark Statute and the safe harbors of the Anti-Kickback Statute are difficult to determine and penalties for violating these laws are harsh, it may be prudent to have a health care attorney review a practice’s particular arrangement to ensure compliance with the law.

Other rules

Becoming knowledgeable of all state and federal regulations that govern a particular ancillary service will help make the new service successful.

One common service that involves regulatory oversight is the addition of an in-office lab. Physicians are required to follow specific guidelines for operating an in-office lab under the Clinical Laboratory Improvement Amendments (CLIA). CLIA established “quality control and assurance procedures, personnel requirements, test management procedures, proficiency testing and inspections on certain laboratories.”

Most in-office physician laboratories operate under a CLIA Certificate of Waiver that allows laboratories to conduct waived tests. Waived tests are defined as “simple laboratory examinations and procedures that have an insignificant risk of an erroneous result.” These tests include urine dip stick tests and blood glucose tests among many others. A complete list of CLIA waived tests is available at: www.cms.hhs.gov/CLIA/downloads/CR5600.waivedtbl.pdf.

To obtain a Certificate of Waiver, the practice must complete an application and pay a biannual fee of $150. Once the waiver is obtained, CLIA’s main rule is that the lab follow the test equipment manufacturer’s instructions for each test offered. Of the total CLIA certificates issued, 60% are Certificates of Waiver.

Informing patients

Patients may not always accept and use the new ancillary service. Patient acceptance of the new service can be estimated by determining how the service fits with your practice. For example, if a family physician adds a new lab, patients may find it easy to accept and use the in-office lab because they are often required to obtain lab work. In contrast, if a family physician opens a cosmetic facility offering Botox and laser procedures, patients may be less accepting because they may not associate primary health care with these services. An estimate of patient’s initial acceptance and use will indicate how to market the new service.

The practice adding a service that fits with its mission (the family physician practice adding a lab) may only need to verbally inform patients that lab services are now available in the office. As long as the lab is covered by the patient’s insurance, it makes sense to assume that patients would like to complete their lab during the visit instead of going to another facility. A family physician practice adding x-ray services may need additional marketing efforts, such as signs announcing the new service, advertisements in the local paper, and a notice on the practice web site. This increased effort is necessary because patients who believe they need x-rays may not seek care at the facility because they are unaware x-rays are available.

The practice adding a disparate ancillary service, (the family physician practice adding a cosmetic facility) may need a full-scale marketing campaign, including print, direct mail, and web site advertising. Because only a limited number of current patients would use the new service, the practice may need to attract new patients who are specifically looking for cosmetic services.

Marketing efforts, however, contain their own inherent risks. These efforts will add another expense to the addition of the service, and this expense should be factored in. The Texas Medical Board enforces specific rules regarding physician advertising, stating: “The Board permits the dissemination to the public of legitimate information, in accordance with the Board’s rules, regarding the practice of medicine and where and from whom medical services may be obtained, so long as such information is in no way false, deceptive, or misleading. It is the responsibility of each physician to carefully scrutinize his advertisements and adhere to the highest ethical standards of truth in advertising.” The TMB’s advertising rules can be reviewed at: http://www.tmb.state.tx.us/rules/rules/164.php.

Following the TMB’s rules will keep physicians practicing within the law, and may also help decrease medical malpractice risk. Certain types of advertising have the potential to create unjustified and misleading expectations in prospective patients. Physicians may inadvertently hold themselves to a higher standard of care with inappropriate advertising. If an advertisement is misleading — making the new service seem to be a cure when no cure exists or the advertisement does not adequately discuss the risks of a new service — patients may use the advertising against the physician in a medical malpractice claim.

To ensure that advertising complies with TMB rules and is not misleading, consider the following:

• Avoid making any guarantees or using any language that may inadvertently cause the practice to be held to a higher standard of care.
• Avoid subjective terms such as beautiful, slim, young, completely cured.
• Claims regarding the experience, competence, and the quality of physicians should only be made if they can be supported by facts. Generalized statements of patient satisfaction should only be made if they are representative of all patients.

Risk management considerations

The addition of any new procedure or service to a practice will increase the physician’s risk of a medical malpractice claim. However, physicians can implement the following steps to reduce these risks.

• Ensure that the physician and staff are properly trained to provide the new service. The amount of training required will depend on the service being offered. Some services may require that the physician attend an off-site training program, while others will involve in-house training of staff. Contact physician colleagues who have implemented the service to discuss training issues. Additionally, document the training that everyone receives.

• Create and follow written policies and procedures regarding the new service. Written policies help to ensure that all members of the care team know their specific duties and the overall intent of the service. Policies and procedures also help when training new staff members. Most importantly, the
policies will create consistency in how the service is offered. When services are consistently offered in the appropriate manner it helps decrease risk.

• Develop an audit process for the new ancillary service. Continually reviewing a practice’s processes provides the opportunity to constantly improve. The audit process should include a review of the medical record documentation to help ensure proper notes are created for the ancillary service. Also, it should include a review of the actual process itself to ensure employees are conducting services appropriately.

• Routinely evaluate each patient’s satisfaction with the new service. Make patient satisfaction surveys available in the waiting area or on the practice web site. Survey patients by mail or phone. These are effective ways to determine how patients feel about the service. Surveys can also help detect problem areas and allow for prompt improvement.

Conclusion

There are many reasons to add ancillary services to a practice: the desire to improve care for patients with more comprehensive services; the desire to learn and expand one’s skills; and the desire for additional profit and growth of the practice. By understanding all the challenges involved in conducting the proper research up front, adding an ancillary service can be an exciting venture with rewards for both the patient and the physician.

Sources


Eldon Volk can be reached at eldon-volk@tmlt.org.
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. Before choosing an ancillary service, the physician should:
   ○ Know the patient demographics and common patient conditions within the practice.
   ○ Understand ancillary services that will be beneficial to a particular demographic.
   ○ Know the total number of individual tests referred outside of the office.
   ○ Question patients as to which ancillary services they desire in the practice.
   ○ All of the above.

2. Common costs when adding an ancillary service include:
   ○ a. The purchase of new equipment
   ○ b. The cost of the space needed for the ancillary service
   ○ c. The need to purchase a vacation, due to the stress of adding an ancillary service
   ○ d. The expense of training and possibly hiring additional staff.
   ○ a, b, and d.

3. All payers reimburse physicians the same amount for ancillary services and require the same documentation:
   ○ True
   ○ False

4. The Stark law prohibits physicians from offering ancillary services such as lab and x-ray in their own practice since they will financially benefit from the self referral:
   ○ True
   ○ False

5. The Anti-Kickback law requires that there is bad intent on the part of the physician before a physician could be prosecuted under this statute:
   ○ True
   ○ False

6. Risk mitigation efforts involved when adding an ancillary service include:
   ○ a. Do not conduct any training for the staff or the physician.
   ○ b. Never establish any written policies and procedures.
   ○ c. Auditing for proper documentation of the ancillary service should not be conducted.
   ○ d. Judging patient's satisfaction of new services is a waste of time.
   ○ The opposite of a, b, c, and d.

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

Physician signature ____________________________ Date ____________________________

Ancillary services
CME evaluation form
Please complete the following regarding the article, "Ancillary services."
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

Ancillary services
Thank you for completing TMLT's 1-hour Reporter CME course, Pediatric Cancer Survivors: Identifying and Treating Late Effects, written by Louise Wailing (July/August issue). In an effort to continuously improve our CME programs, we would appreciate your response to the short survey below.

Once you have completed the survey, please fax it to TMLT's Risk Management Department at 512-425-5996, attention Stephanie Downing. You may also mail the survey to Stephanie Downing, TMLT Risk Management Department, P.O. Box 160140, Austin, Texas 78716.

To express our appreciation for completion of this survey, we are offering one free on-line CME course, to be taken between November 1 and December 1, 2007. Once you have completed and sent in the survey below, contact Stephanie at stephanie-downing@tmlt.org or (800) 580-8658, ext. 5919 to request the course access code. Once you have the code, go to www.tmlt.org, select an on-line course and enter this code for free access. First time users must enroll as a student. Enrollment is free.

If you experience any difficulty or have any questions, please contact TMLT at (800) 580-8658, ext. 5911. Thank you for sharing your opinions.

Read each question, select the best answer, and then clearly mark your selection using black ink.

Since completing the Pediatric Cancer Survivors course, are you able to:

1. list three late effects commonly associated with childhood cancer treatment?
   ○ Yes
   ○ No, not at this time
   ○ No, but planning to soon
   ○ Other

2. identify the primary assessment tool for identifying late effects?
   ○ Yes
   ○ No, not at this time
   ○ No, but planning to soon
   ○ Other

3. list the source for updated guidelines for the follow-up treatment of late effects?
   ○ Yes
   ○ No, not at this time
   ○ No, but planning to soon
   ○ Other

Have you found the information provided by the author to be helpful in your practice?

○ Yes  ○ No

Based on this CME course, what specific changes did you implement in your practice?
Stent placed in the wrong kidney

by Barbara Rose and Laura Brockway

Presentation
A 43-year-old woman came to the emergency department (ED) with pain and pressure in the bladder area, back pain, and a history of urinary tract infection. A CT scan revealed a 6 mm stone in the right ureter with no urinary disease on the left. The ED record referred to a ureter stone on the left.

Physician action
A urologist was consulted. The next day, he placed a stent in the left ureter. At the time of the stent placement, a left retrograde pyelogram was performed, but there was no right retrograde pyelogram performed. The patient was discharged.

The patient returned to the hospital two days later, and a KUB revealed the stone on the right side. The urologist removed the stent on the left and placed a stent in the right ureter. A left ureteroscopy was also performed.

The next day, the patient went to another hospital with inability to urinate and severe abdominal pain, bloating, and distension. She was diagnosed with acute renal failure with a creatinine of 4.2. A left ureteral perforation was suspected, and she underwent a left nephrostomy tube placement. The patient eventually underwent a right nephrectomy because of severe hydronephrosis and non-function of the right kidney. The patient regained normal function of her left kidney.

Allegations
A claim was filed against the urologist. The patient alleged that the urologist improperly and unnecessarily placed a stent on the left side that caused an obstruction and the need for a temporary nephrostomy tube. The patient did not claim that the subsequent right nephrectomy was caused by the urologist’s negligence.

Legal implications
Urologists who reviewed this case for the defense were critical of the treating urologist’s actions. The urologist stated in his office notes that the stent was placed in the left ureter “by information given to him” rather than by him reviewing the CT scan, radiology report, and examining the patient. “An adequate history and physical should have alerted the insured that the problem was the right kidney, and it was clear on the CT scan that the problem was with the right kidney originally.” Though the urologist was arguably relying on the ED physician’s incorrect documentation, the urologist was ultimately responsible for operating on the correct side.

The experts also stated that the delay in stenting the right kidney did not cause the loss of that kidney. According to the urologists, the patient had a long-standing obstruction to the right kidney with pyelonephrosis and loss of function. The loss of the right kidney would have occurred even if the urologist had placed the stent in the correct side.

Disposition
This case was settled on behalf of the urologist.

Risk management considerations
With all the attention paid in recent years to medical errors and the increased efforts to implement protocols to assure patient safety and quality care, one would expect improved experience in the number of wrong site mistakes. The summary of this claim indicates that they can still occur.

Physicians are generally expected to review a patient’s history and perform a physical exam to determine their findings and recommended course of care. Notes from other health care professionals are only one of the tools available to the physician. Reviewing radiologists’ reports, checking the medical record (including informed consent forms), and conducting a “time out” to verify the right patient and correct site for a procedure is a protocol to be consistently followed.

The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) recommends the following processes to identify the correct surgical site, patient and procedure by: “1) marking the surgical site and involving the patient in the marking process; 2) creating and using a verification checklist including appropriate documents, for example, medical records, X-rays and/or imaging studies; 3) obtaining oral verification of the patient, surgical site, and procedure in the operating room by each member of the surgical team; and 4) monitoring compliance with these procedures. Additionally, Joint Commission recommends that 5) surgical teams consider taking a ‘time out’ in the operating room to verify the correct patient, procedure and site, using active — not passive — communication techniques.”

Sources

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Failure to follow patient while prescribing narcotics

by Barbara Rose and Laura Brockway

Presentation
A 43-year-old woman came to an ob-gyn’s office on February 18 complaining of acute pelvic pain. The patient told the ob-gyn that she had undergone LASIK surgery 13 months ago, and had developed a painful eye condition after the surgery. The ob-gyn noted the condition as “hormone dependent,” and that it seemed to worsen as the patient’s menses became more irregular. The patient had seen a number of physicians to resolve her eye condition, but no treatment had been successful. The patient reported that she was taking 32 hydrocodone tablets per day to manage her pain. (The ob-gyn did not document this statement in the patient’s chart and pharmacy records did not show she was receiving this much hydrocodone.)

Physician action
After taking the patient’s history, the ob-gyn ordered a pelvic ultrasound that revealed uterine fibroids, possible adenomyosis, and a multi-septate cystic mass on the left adnexa. Because of the patient’s symptoms of irregular periods, continuous cramping, low back pain, and nausea, the ob-gyn recommended a laparoscopic hysterectomy.

The hysterectomy was completed on March 5, and the patient remained in the hospital for two days. Approximately 48 hours after surgery, the ob-gyn prescribed a 20 mg dose of OxyContin for the patient’s postoperative pain. The ob-gyn later testified that the patient’s entire demeanor improved dramatically after the first dose. The patient reported that her eye pain was relieved by the OxyContin.

On March 7, the patient was discharged with prescriptions for eighty 20 mg tablets of OxyContin and one hundred 5 mg tablets of Oxycet for breakthrough pain. The patient was instructed to take one to two 20 mg tablets two times per day for 14 days and then to taper off the doses. (This dosage complies with the suggested dosage guidelines printed in the package insert.) The prescription was intended to last the patient until her scheduled follow-up visit of April 10.

The patient called the ob-gyn’s office on April 1. The patient, who was out of the state, called requesting an OxyContin prescription because she left all her medications to include Xanax and naltrexone. The psychiatrist noted that the patient had “unilaterally discontinued her medications to include Xanax and narcotics in one to two days prior to admission and was in apparent withdrawal syndrome.” The patient was “detoxed” from her OxyContin, and discharged on April 30 with good mental and emotional condition.

Allegations
A lawsuit was filed against the ob-gyn, alleging that she failed to see the patient in regular follow up while continuing to prescribe OxyContin. The plaintiff further alleged that she suffered withdrawal symptoms and incurred medical costs associated with this treatment.

Legal implications
The plaintiffs retained expert testimony to support their allegations. Their ob-gyn expert was critical of the defendant for prescribing OxyContin for the patient’s eye pain, and for refilling the prescription without seeing the patient or monitoring how the patient was doing. This expert argued that patients who are prescribed medication for chronic pain should be seen monthly.

The plaintiff’s psychiatry expert stated that the standard of care requires a physician to assess the patient every time a prescription for OxyContin is written. However, when asked for any guidelines that might support this statement, he was unable to provide any.

An ob-gyn who reviewed this case for the defense argued that the defendant was not negligent in prescribing OxyContin while the patient was out of the state. The ob-gyn’s assessment was a “normal postoperative exam,” and her plan notes stated the patient was to return in one year for a gynecological exam unless new problems arose. She also noted the patient was to “continue OxyContin due to eye pain . . . she feels much better on it and has no sedation with it.” The patient was given a prescription for eighty 20 mg tablets of OxyContin to be taken every 12 hours.

The patient never returned to the ob-gyn after this office visit. However, she did contact the office for refills of her OxyContin on eight occasions over the next 10 months. The patient never called for a refill before the prescription was due to be refilled.

The patient’s health deteriorated, and she was treated by an internal medicine physician, a gastroenterologist and a rheumatologist. The patient underwent an EGD on September 23 that revealed an esophageal polyp. This physician indicated in his notes that the patient should continue on her present medications.

Around April 20, approximately one year after the hysterectomy, the patient decided to discontinue OxyContin without consulting the ob-gyn or any other physician. On April 22, the patient was admitted to a regional hospital with major depressive symptoms and suicidal ideation “in the context of chronic pain.” At the time of admission, the psychiatrist noted that the patient had “unilaterally discontinued her medications to include Xanax and narcotics in one to two days prior to admission and was in apparent withdrawal syndrome.” The patient was “detoxed” from her OxyContin, and discharged on April 30 with good mental and emotional condition.

continued on page 18
OxyContin or in her monitoring of the patient while on the drug. He questioned whether a physical exam of the patient each time a prescription was given would have revealed any problem the patient was having with OxyContin. Additionally, the patient never reported any problems with pain or any change in symptoms when she asked for refills.

The defense pain management specialist testified OxyContin was a safer medication than the hydrocodone the patient had been taking. Additionally, the patient was dependent on OxyContin and required weaning from the drug. She might not have required the hospitalization for detoxification had she advised the ob-gyn or another physician that she was stopping the medication. The patient even testified that the ob-gyn told her to wean herself from the medication when she was discharged from the hospital on March 7.

Disposition

This case was settled on behalf of the ob-gyn. Though experts supported the actions of the defendant, criticisms remained about documentation of the patient’s refills.

Risk management considerations

Once this patient’s recovery from the hysterectomy was deemed satisfactory, a referral back to an eye specialist to evaluate and determine the plan of care for unresolved eye pain seemed appropriate. A direct referral to a pain management specialist could also have been initiated.

Physician reviewers of this case expressed criticisms about the absence of documentation of the initial pain assessment and reasons for treating this patient’s pain. Because the patient was told to return for an annual exam without any interim follow up, periodic visits and reassessment of the patient’s eye pain were not documented in the record. Vigilance is required when prescribing and monitoring medications known to lead to dependence.

The physician’s documentation is expected to include a comprehensive assessment of pain, the options available for intervention and treatment, and the reasons for the plan of care. For a patient taking a drug known to cause dependence, periodic office visits and reassessments are in that patient’s best interests. These visits can also assure the physician stays well informed about the management of chronic pain.

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