Physician impairment
a proactive approach

by Laura Brockway, ELS

Case study
Anesthesiologist A was a partner at XYZ Anesthesiology Associates and practiced at Hospital A. He was fired “with cause” from XYZ Anesthesiology Associates after he came to work in an impaired condition. (Anesthesiologist A was diverting and using Demerol) Subsequently, Anesthesiologist A was hired by Hospital B. During a routine tubal ligation at Hospital B, Anesthesiologist A prematurely extubated the patient while she was still under the influence of anesthesia and refused to call a code when the nurses noted the patient did not have a pulse. The patient has been in a vegetative state since the surgery. Anesthesiologist A was impaired by narcotics at the time of the surgery. The patient’s family sued Hospital B and Anesthesiologist A. Hospital B settled the case for several million dollars.

Hospital B then went on to sue Hospital A and XYZ Anesthesiology Associates alleging intentional and negligent misrepresentation. Hospital B’s request for information and references from Anesthesiologist A’s former employer failed to uncover Anesthesiologist A’s history of narcotic use. According to the complaint, two former colleagues of Anesthesiologist A and Hospital A failed to disclose relevant, material information. The two former partners had written positive letters of recommendation for Anesthesiologist A and Hospital A did not send complete credentialing information. Additionally, Anesthesiologist A was not reported to the National Practitioner Databank. This lack of “truthful communication” may have led to the hiring and

continued on page 2
Physician impairment

The American Medical Association defines an impaired physician as one who is “unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.”

Though the exact rate is unknown, studies indicate that between 8% and 12% of physicians will develop a substance use disorder during their lives. This is the same rate found in the general population. However, abuse of prescription drugs—particularly benzodiazepines and opiates—is more prevalent among physicians probably due to availability and familiarity with these drugs.

An article published in the Annals of Internal Medicine estimated the incidence rates of physician impairment from mental illness, alcohol dependence and drug abuse, disruptive behavior, physical illness, and declining competencies and concluded that “When all conditions are considered, at least one-third of all physicians will experience, at some time in their career, a period during which they have a condition that impairs their ability to practice medicine safely; for a hospital with a staff of 100 physicians, this translates to an average of 1 to 2 physicians per year.”

Signs and symptoms

“For healthcare professionals, deterioration in clinical performance is usually one of the last signs of a substance abuse disorder. When the healthcare professional’s work performance is affected, the problem is usually well advanced and severe. Professional performance of healthcare providers is often protected at the expense of other personal, social, and family obligations.”

Signs and symptoms of substance abuse that may be seen in physicians include:

- inaccessibility to patients and staff;
- completing rounds at odd hours;
- decreased chart performance;
- ordering large quantities of drugs;
- issuing inappropriate orders or prescriptions;
- forgetting oral orders;
- slurred speech during off-hour phone calls;
- heavy drinking at hospital or office functions;
- multiple prescriptions for family members;
- arriving late for appointments;
- increased absences and unexplained disappearances during work hours;
- increased patient complaints;
- increased secrecy;
- decreased productivity;
- decreased quality of care;
- increased conflicts with colleagues;
- vague letters of reference; and
- erratic job history that includes new jobs in different locations and unexplained time off between jobs.

Signs of impairment from physical or mental illness may be similar to those listed above. “Disorders most commonly diagnosed in physicians include those of mood [major depression, dysthymic disorder, and bipolar disorder], cognition, chemist misuse, panic/anxiety and obsessive-compulsiveness. The most commonly encountered personality disorder traits are narcissism, obsessive-compulsiveness and antisocial.”

Physicians with a substance use disorder may have a coexisting psychiatric disorder, and if both conditions are not treated, the success rates of treatment will suffer for each.

Physician health committees

“Historically, addicted physicians either went unnoticed or were treated punitively. In 1973, the American Medical Association recommended, in a landmark report entitled ‘The Sick Physician,’ that state medical societies establish programs to identify and treat impaired physicians. Since that time, every state has established a program or committee for that purpose.”

In Texas, the Committee on Physician Health and Rehabilitation (PHR) of the Texas Medical Association promotes the health and well-being of physicians as well as the treatment and rehabilitation of those who have become impaired. “As advocates, the committee helps with intervention, referral for evaluation and treatment, monitoring upon return from treatment, and education for physicians, family members and support staff regarding possible impairments.” The committee’s activities include operating a 24-hour, toll-free number at 800-880-1640 to respond to referrals concerning physicians who may be impaired.

Types of impairments or conditions addressed by the TMA PHR Committee include:

- drug or alcohol dependence 73%
- disruptive behavior 4%
- sexual misconduct 4%
- depression/mood disorders 6%
- stress/overwork 2%
- other psychiatric disorders 11%

“The majority of cases referred to Texas county medical society PHR committees have involved substance abuse or dependence. However, as hospitals and medical societies are more aware of physician impairment, disruptive and dysfunctional behaviors of all types are being reported. Frequently, a psychiatric illness is at the root of the behavior, and these illnesses, although often difficult to identify, are treatable.”

In addition to state and county medical societies, hospitals and residency programs have also established physician health programs. In 2002, the Joint Commission and the Accreditation Council for Graduate Medical Education
mandated that training programs and hospitals “establish processes and programs designed to detect, intervene, treat, and rehabilitate the impaired physician that is separate from the medical staff disciplinary process.”3

“The purpose of separating health matters from disciplinary matters is to encourage the implementation of a process that will not damage the physician’s reputation as a result of impairment. The goal is to identify health-related problems at an early stage, put supportive services in place, and implement necessary safeguards to protect the safety of patients while (if possible) allowing the physician to remain in practice.”7

Reporting impaired physicians

Although the signs and symptoms of impairment can be obvious, many physicians are hesitant or unwilling to report impaired colleagues. “Many physicians are reluctant to confront behavioral or competence problems. Independence is so highly valued that physicians are loath to evaluate or confront a colleague whom they perceive as having a problem. Doctors abhor making judgments about colleagues who may also be personal friends or practice partners. Department chairs often lack the training and skills needed for managing doctors who perform poorly. The hospital may need the physician’s revenue stream.”4

A study reported in the *Annals of Internal Medicine* found that 96% of 1,662 surveyed physicians agree that physicians should report impaired or incompetent colleagues to relevant authorities. However, 45% of those respondents with “direct personal knowledge” of an impaired or incompetent physician did not report that physician.8 A similar survey of physicians published in *Social Science and Medicine* found that physicians are more likely to report impairment due to substance abuse than impairment due to cognitive or psychological problems.9

In Texas, a physician’s duty to report an impaired colleague is spelled out in the Medical Practice Act. The Act specifies that any physician, medical student, resident, or medical peer review committee “shall report relevant information to the board [TMB] relating to the acts of a physician in this state if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine.”10

Accordingly, if in the physician’s opinion the colleague “poses a continuing threat to the public welfare through the practice of medicine” then that colleague must be reported to the board.10 Otherwise, the physician can report concerns to the local or hospital physician health committee and may also report these problems to the TMB.

“Contacting a PHP [physicians health program] can be done anonymously and is usually better than trying to confront the individual directly since most addicted physicians have high levels of denial. . . . However difficult it might be to report a colleague, impaired physicians cannot be allowed to continue to put the lives of their patients at risk through negligence, misconduct, or avoidable harm.”6

It is important for physicians to realize that Texas physician-health and rehabilitation programs are designed to rehabilitate physicians, not punish them. Generally, reporting to the TMB is not required when the physician complies with treatment and rehabilitation guidelines.

The TMA PHR committee works through county medical society-based committees and state committee-appointed district coordinators, to investigate reports of potential impairment. Initially, the committee’s approach is one of “anonymity and advocacy.” If the investigation reveals sufficient evidence to suggest a problem, an intervention will occur. The goal of the intervention is to have the physician agree to stop practicing, undergo an evaluation, and follow through with treatment recommendations. Upon the physician’s return from treatment, the committee enters an agreement with the physician for monitoring purposes. The physician can return to practicing medicine, provided that he or she adheres to the committee’s requirements.

If the physician refuses help or the committee believes that the physician “poses a continuing threat to the public welfare through the practice of medicine” the law requires the committee to report the physician to the TMB and any known health care entity in which the physician has clinical privileges. “This reporting obligation is often the final leverage utilized by the committee to persuade a physician to work with the physician health and rehabilitation committee.”11

“At this point in the intervention, some physicians will insist that they can take care of the problem by themselves, but we tell them that if they do not agree to an evaluation or seek treatment, we have no alternative but to report them to the board and their hospital(s),” says John Jackson, MD, chair of the TMA’s PHR Committee.

Additionally, if the physician does not uphold the agreement with the committee—for example by not following treatment recommendations or by violating a post-treatment monitoring agreement—the committee may report the physician to the TMB. “We explain all this to the physicians so they know exactly what they are expected to do and what will happen if they don’t,” says Dr. Jackson.

The PHR committee’s response to physicians who are impaired follows the responsibilities outlined in the AMA Code of Medical Ethics. ‘Physicians’ responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program. Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians’ obligation to protect patients against harm, may entail reporting to the licensing authority.”12

For physicians who are uncertain if their suspicions mean a physician is impaired, Dr. Jackson recommends seeking assistance from the local or state physician health committee. These committees have experience in discreetly looking into such issues and making decisions and recommendations. “I have often talked with concerned physicians without ever asking the name of the doctor about whom the concern exists. Once I can show that the committee’s interest is in helping the doctor, any reluctance to identify him or her is usually abandoned,” says Dr. Jackson.

Rehabilitation orders

The TMB also may take a “non-stigmatizing approach” toward physician impairment. According to the Medical Practice Act:

“(a) The board, through an agreed order or after a contested proceeding, may impose a nondisciplinary rehabilitation order on an applicant, as a prerequisite for issuing a license, or on a license holder, based on:

(1) Intemperate use of drugs or alcohol directly resulting from habituation or addiction caused by medical care or treatment provided by a physician;
(2) self-reported intemperate use of drugs or alcohol during the five years preceding the report that could adversely affect the reporter’s ability to practice medicine safely; if:

(A) the reporting individual has not previously been the subject of a substance abuse-related order of the board; and

(B) the applicant or license holder has not committed a violation of the standard of care as a result of the intemperate use of drugs or alcohol;

(3) a judgment by a court that the applicant or license holder is of unsound mind;

(4) a determination of impairment based on a mental or physical examination offered to establish the impairment in an evidentiary hearing before the board in which the applicant or license holder was provided an opportunity to respond; or

(5) an admission by the applicant or license holder indicating that the applicant or license holder suffers from a potentially dangerous limitation or an inability to practice medicine with reasonable skill and safety by reason of illness or as a result of any physical or mental condition.

(b) The board may not issue an order under this section if, before the individual signs the proposed order, the board receives a valid complaint with regard to the individual based on the individual’s intemperate use of drugs or alcohol in a manner affecting the standard of care.

(c) The board must determine whether an individual has committed a standard of care violation described by Subsection (a)(2) before imposing an order under this section.

(d) The board may disclose a rehabilitation order to a local or statewide private medical association only as provided by Section 164.205. 13

Unlike other TMB disciplinary orders, rehabilitation orders are confidential and are not available to the public or managed care plans, and are not reported to the National Practitioner Databank. 14 However, rehabilitation orders “can include the full range of actions of a disciplinary order, including revocation, cancellation, suspension, and various terms and conditions of probation. The most common rehabilitation order for a physician who self-reports is probation for a number of years under certain terms and conditions. These conditions are intended to not only monitor a physician in recovery, but also to rehabilitate the physician.” 15

Physicians can self-report impairments by sending a written report directly to the TMB or by filling out the online complaint form at the TMB web site. Physicians also have the option of reporting impairments on their annual license renewal form. 16 In fiscal year 2007, the TMB issued 57 rehabilitation orders. 16

Recovery rates for physicians

The outcome of substance abuse treatment is generally more favorable for physicians than for the general public. Reported abstinence rates for physicians vary from 70% to 90%. Treatment programs estimate that 75% to 85% of physicians return to work. 1 This is likely due to close monitoring and “highly motivated physicians who have a tremendous amount to lose professionally and personally if they relapse.” 6

Resources

The TMA Committee on Physician Health and Rehabilitation
800-880-1640
http://www.texmed.org/Template.aspx?id=4751

The Texas Osteopathic Medical Association
Physicians Health and Rehabilitation Committee
800-896-0680 or (512) 257-0927

The Texas Medical Board
(512) 305-7010
http://www.tmb.state.tx.us/

American Society of Addiction Medicine
www.asam.org

American Academy of Addiction Psychiatry
www.aaap.org

Alcoholics Anonymous
www.aa.org

Association for Medical Education and Research in Substance Abuse
www.amersa.org

Caduceus Groups
Caduceus groups are self-help groups for physicians and other health care professionals who are recovering from chemical dependence. TMA PHR staff can put you in contact with group members who can describe the structure and membership of their specific Caduceus group. Contact them at (800) 880-1300 or (512) 370-1300.

International Doctors in Alcoholics Anonymous
www.idaa.org

Smart Recovery
http://www.smartrecovery.org/

Physician health committees typically monitor physicians in recovery for five years, but some may monitor longer. A monitoring program includes random drug screens; written reports from counselors or therapists; self reports provided by the physician in recovery; and written verification of attendance at self-help or support group meetings. 2

Conclusion

“Patients, family members, friends, and professional colleagues have a moral responsibility and obligation to identify healthcare professionals who are impaired. Once an impaired health care professional is identified, resources offering treatment interventions, rehabilitation, and assistance with reentry into clinical practice at the institutional, local, and state level are available. Timely identification, treatment, and follow-up care will allow impaired providers the opportunity to heal and to be successful in their clinical careers and personal lives.” 3

continued on page 20
The TMLT Board of Governors has approved an average 4.7% rate reduction for TMLT-insured physicians and a 22.5% dividend for renewing policyholders, effective January 1, 2009. The dividend will be applied at policy renewal.

“TMLT has now reduced rates for Texas physicians six consecutive years since the passage of House Bill 4 and Proposition 12 in 2003,” says Bob Fields, president and CEO of TMLT. For the first five years, rates were reduced across the board for all specialties: 12% in 2004; 5% in 2005; 5% in 2006; 7.5% in 2007; 6.5% in 2008. For 2009, all specialties will receive a rate decrease, but the reduction will vary by specialty and practice location with an average decrease of 4.7%. According to Fields, the cumulative premium savings realized by policyholders will exceed $275 million since January 2004.

“This is the fourth consecutive year the Trust has announced a policyholder dividend,” says Fields. “The 22.5% dividend is the largest percentage dividend in the Trust’s history. Since the first dividend was declared in 2005, renewing TMLT policyholders will have received dividend credits off renewal premiums amounting to approximately $105 million.”

Since the passage of medical liability reform, TMLT insured physicians will have saved $380 million in decreased premiums, once this latest round of rate cuts and dividends is implemented.

Effective medical liability reform has continued to reduce nonmeritorious litigation against physicians. As long as 2003 reform measures remain in place, TMLT believes the legal environment will remain stable. TMLT’s current strong financial position makes these rate reductions and dividends possible; however, there is no guarantee that the business and legal climate will support future rate reductions or dividends. The TMLT Governing Board, executive management, and financial consultants determine rate reductions and dividend considerations annually.

TMLT offers fall CME program

This fall, the TMLT Risk Management Department will offer the CME seminar series “Health Care Rock ‘n’ Roll: Medicine in Transition.” The seminar will address emerging health care trends with an emphasis on new technology and communication. Seminar topics include:

• emerging trends in medicine;
• the changing demographics of medicine;
• preserving professionalism: balancing medicine with family;
• crossing the technology divide: different modes of communication;
• issues surrounding hospitalization;
• communication between consulting physicians;
• when consulting physicians don’t agree;
• preserving relationships;
• adapting to technology to enhance patient care; and
• medicine in transition: the next frontier.

The seminars are led by Sarah Fontenot, BSN, JD. Sarah specializes in health law and presents medical-legal seminars throughout the country. She teaches health law in the Department of Health Care Administration at Trinity University in San Antonio, and is a faculty member for the Certificate in Business Administration program jointly offered by Auburn University and the Southern Medical Association.

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 at their next eligible policy period. Course dates and locations are:

Thursday, October 16, 2008
Fort Worth Renaissance Worthington Hotel
200 Main Street

Thursday, October 23, 2008
Houston Marriott Medical Center
6580 Fannin Street

Tuesday, October 28, 2008
Austin Renaissance Hotel
9721 Arboretum Blvd

Thursday, October 30, 2008
Houston Marriott Medical Center
6580 Fannin Street

Tuesday, November 11, 2008
San Antonio Marriott NW
3233 NW Loop 410

Tuesday, November 18, 2008
Dallas Renaissance Hotel
2222 Stemmons Freeway

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 the online CME section of 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. 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 2008, we received 33 applications from students at eight Texas medical schools. We are proud to introduce the recipients of the 2008 TMLT Memorial Scholarships:

**Alexander J. Alvarez** is a third-year medical student at the University of Texas Southwestern Medical School.

**Megan Gentry** is a third-year medical student at the University of Texas Health Science Center at San Antonio.

**Douglas James Heiner** is a third-year medical student at the University of Texas Southwestern Medical School at Galveston.

**Michael Merrick** is a fourth-year medical student at the University of Texas Medical Branch at Galveston.

**Ana Nguyen** is a fourth-year medical student at the Texas Tech University Health Science Center School of Medicine.

**Kyle Piwonka** is a fourth-year medical student at the University of North Texas Health Science Center Texas College of Osteopathic Medicine.

**Jenny Van Winkle** is a fourth-year medical student at the Texas A&M University System Health Science Center College of Medicine.

**Ajit Vyas** is a fourth-year medical student at Baylor College of Medicine.

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

The TMLT Memorial Scholarships 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. 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 2008, we received 33 applications from students at eight Texas medical schools. We are proud to introduce the recipients of the 2008 TMLT Memorial Scholarships:

**Alexander J. Alvarez** is a third-year medical student at the University of Texas Southwestern Medical School.

**Megan Gentry** is a third-year medical student at the University of Texas Health Science Center at San Antonio.

**Douglas James Heiner** is a third-year medical student at the University of Texas Southwestern Medical School at Galveston.

**Michael Merrick** is a fourth-year medical student at the University of Texas Medical Branch at Galveston.

**Ana Nguyen** is a fourth-year medical student at the Texas Tech University Health Science Center School of Medicine.

**Kyle Piwonka** is a fourth-year medical student at the University of North Texas Health Science Center Texas College of Osteopathic Medicine.

**Jenny Van Winkle** is a fourth-year medical student at the Texas A&M University System Health Science Center College of Medicine.

**Ajit Vyas** is a fourth-year medical student at Baylor College of Medicine.

For the essay assignment, students were asked to write risk management considerations for a closed clam study provided by TMLT. The case study and recipients’ essays follow.
At 1:50 p.m., the pediatrician ordered a repeat CBC, blood culture, a DIC and renal panel, and an echocardiogram. The child was started on Vancomycin and gentamycin. At 2:35 p.m., her blood pressure dropped to 82/42 mm Hg. The infectious disease specialist ordered a fluid bolus of normal saline and an empiric dose of Rocephin 500 mg IV. Her blood pressure improved, but dropped again to 73/40 mm Hg at 3:30 p.m., prompting an additional fluid bolus of 500 cc normal saline. From 3 p.m. to approximately 6:15 p.m., the patient’s blood pressure remained in the 90s/30s. Dopamine infusion was started, and the patient received multiple fluid boluses. She was intubated at 5:15 p.m., and one hour later large amounts of blood came through the endotracheal tube. A chest x-ray showed bilateral fluffy infiltrates, consistent with a pulmonary hemorrhage. The patient received platelet and red cell transfusions.

At 7 p.m., the patient became bradycardic and required chest compressions. She was given bicarb, calcium, insulin, glucose and epinephrine. Although she was briefly stabilized, she coded again at 7:40 p.m. Resuscitation efforts continued, but they were not successful. The patient was pronounced dead at 8:55 p.m.

An autopsy was performed and the pathologist concluded that the patient died from Group A Beta hemolytic streptococcal sepsis that resulted in acute infectious purpura fulminans and marantic endocarditis.

Allegations

Lawsuits were filed against the hospital, Emergency Physicians A and B, Pediatrician A, and Orthopedic Surgeons A and B. The allegations included:

- failure to institute antibiotic therapy after receiving the first lab results (Emergency Physician A);
- failure to call in the orthopedic surgeon on a “stat” basis and failure to stress the septic condition of the patient sufficiently to prompt Orthopedic Surgeon A to come immediately (Emergency Physician B);
- failure to obtain an emergent consult from another physician when Orthopedic Surgeon A failed to come in (Pediatrician A and Emergency Physician B); and
- failure to make themselves present in a case where a patient had labs indicative of a septic joint and developing septicemia (Orthopedic Surgeons A and B).

Legal implications

The plaintiffs were able to obtain support for their allegations from a pediatric infectious disease specialist. He stated that the ED physicians should have considered septic arthritis as the first diagnosis in their differential diagnosis and arranged urgent orthopedic consultation for aspiration of the child’s right knee. Once the fluid was sent for culture, the standard of care required that the child be started immediately on IV antibiotics pending the results of the culture and rheumatologic studies. The ED physicians and the pediatrician should have insisted that Orthopedic Surgeon A or another orthopedic surgeon perform an arthrocentesis, and failure to do this was a violation of the standard of care. Further, this failure was a direct cause of the child’s bacteremia, septic shock, and death. If antibiotics had been started in the ED, this patient likely would have survived.

An orthopedic surgeon who testified for the plaintiffs stated that the orthopedic standard of care for a possible infected knee joint is either to come in and aspirate the joint, or if the ED physician feels competent, have that physician aspirate the joint for culture and sensitivities. Antibiotics should then be promptly started until the culture growth can be established. Aspiration of the joint before starting antibiotics in a possible infected joint is the standard of care, rather than empirically starting antibiotics without this culture. Doing a blood culture alone is not the standard of orthopedic care. According to this expert, Orthopedic Surgeon A did not meet the standard of care.

Several consultants reviewed this case for the defense. The orthopedic surgeons blamed Pediatrician A and Emergency Medicine Physicians A and B. The pediatric consultants blamed Orthopedic Surgeon A. The emergency medicine physicians were critical of everyone. They felt that had antibiotics been started in the ED, and had the ED physicians been trained to do arthrocentesis, they could have prevented the death of this patient. The pediatric infectious disease consultants were all concerned that with a severe left shift, antibiotics should have been started sooner. Only one physician who reviewed this case stated that the patient’s survival was unlikely, and antibiotics given early in the morning would not have made much difference in the outcome.

Finger pointing among the physicians further complicated the defense of this case. Emergency Physician B stated that if asked, he would testify that he spoke with Orthopedic Surgeon A twice between 1:30 and 2:30 a.m. During the first conversation, he said the patient had a severe left shift in her labs and looked to have a septic joint. He asked Orthopedic Surgeon A to do an arthrocentesis immediately. Orthopedic Surgeon A said she would perform it in the morning, and she ordered that no antibiotics be given so the culture would be accurate. Orthopedic Surgeon A told Emergency Physician B not to call her back. After obtaining the results of the MRI, Emergency Physician B called her back to give her the results. She still did not come in.

Emergency Physician B then alerted Pediatrician A to this fact, but Pediatrician A did not order an arthrocentesis from another physician. She agreed to wait until morning. When Pediatrician A arrived at the hospital at 8 a.m., she expected that the tap had been completed. When she learned that it had not, she was concerned. Orthopedic Surgeon B testified that had Pediatrician A or Orthopedic Surgeon A stated that he was urgently needed, he would have seen the patient sooner. Orthopedic Surgeon B was surprised that Pediatrician A and the nurses waited so long to call him and failed to involve an intensivist and infectious disease specialist earlier.

Disposition

This case was settled on behalf of Pediatrician A and Orthopedic Surgeon A. The hospital also settled their case. The cases against Emergency Medicine Physicians A and B and Orthopedic Surgeon B were dismissed.
As was outlined in the case allegation, there were multiple factors that contributed to this patient’s unfortunate death. Emergency Physicians A and B clearly acted according to the standard of care, as was stated in the orthopedic surgeon’s testimony. He stated that the standard of care for a possible septic joint is either (1) for the orthopedic surgeon to come in and aspirate the joint or (2) for the ED physician to aspirate if he feels competent to do so. According to the statements of the ED physicians, they were not trained to properly perform arthrocentesis, so only option (1) followed standard of care. Emergency Physician A ordered an MRI to work up a suspected diagnosis of septic joint after seeing a left shift in the labs of a non-diagnostic plain film. The results didn’t come back until Emergency Physician B was on duty, at which point the diagnosis was correctly made as “right knee effusion/pain; concern for septic joint.” Emergency Physician B immediately contacted Orthopedic Surgeon A to perform an arthrocentesis. She said he would come in the morning, and not to call back. However, Emergency Physician B called again an hour later to reiterate the need for the procedure, and Orthopedic Surgeon A still did not come in. Pediatrician A, who was assigned the case, was surprised to arrive at 8 a.m. and find the arthrocentesis was not performed. He saw Orthopedic Surgeon A outside the patient’s room at this time, and requested she come in to perform the tap. Orthopedic Surgeon A again declined, stating that she had an emergency and would refer the case to his colleague, Orthopedic Surgeon B. However, as Orthopedic Surgeon B testified, it was not made clear to him by Orthopedic Surgeon A that this was an urgent situation, so he decided to come after clinic. By the time he arrived, the patient was septic, and expired soon after admission to the ICU.

It is clear that Orthopedic Surgeon A was negligent in her care. Both Emergency Physicians ordered the appropriate tests, made the correct diagnosis, and consulted a specialist to perform a procedure that was out of their scope of skill. Pediatrician A trusted the specialists interpretation and decided to wait until 8 a.m. for the procedure to be performed, and when that had not occurred, made a good faith effort to have the procedure done by again requesting it from Orthopedic Surgeon A. Orthopedic Surgeon A then failed to reiterate to Orthopedic Surgeon B the urgency of the situation, and left without performing the procedure. In the end, Orthopedic Surgeon A refused three times to do the procedure, and failed to insure continuity of care with Orthopedic Surgeon B. The situation could have been avoided in a number of ways: (1) ED physicians could be trained to competently perform necessary procedures that may need to be done on an emergent basis (2) Orthopedic Surgeon A was negligent on her duty to perform the arthrocentesis on three occasions despite indications that this was a septic joint and antibiotic therapy was necessary (3) Orthopedic Surgeon A could have exercised better communication to her colleague to insure an accurate picture of the patient’s status was reflected, so that the proper care would be received (4) Any of the physicians in this case could have been more proactive in getting someone to perform the arthrocentesis, instead of relying solely on Orthopedic Surgeon A. Though Orthopedic Surgeon A is the specialist, this does not shirk the responsibility of the other physicians to insure care is received in an appropriate and timely manner.

Blame is easily assigned in hindsight, but applying discerning foresight reduces the risk of preventable medical error. One decision did not lead to the unnecessary death of this patient. Instead, a plethora of missteps allowed simple medical procedures to be ignored while this patient’s chances of diagnosis and recovery slipped away.

First, hospital bureaucracy spawned an environment that allowed responsibility to be jostled from doctor to doctor. Even when simple medical diagnostic clues presented themselves, no doctor claimed responsibility and initiated a viable treatment plan, shifting the patient’s care onto the shoulders of another. This negligence allowed the patient’s life to fall fatally through the cracks.

Secondly, a number of ignored diagnostic flags also contributed to the death of this patient. The patient presented with classic septic arthritis; monoarticular joint pain, fever, erythema, and edema. A history 18 months earlier for septic bursitis should have strongly alerted the physician to this patient’s propensity for joint infection. Lab results showing a strong left shift and elevated inflammatory markers gave support to the primary concern of bacterial infection. Lastly, the progression of the infection to the other leg, plus the appearance of the petechial rash, indicated rapid spread from the primary infection site. By the time antibiotics were finally administered, bacteremia was imminent and attempts at resuscitation were futile. The heart of the young patient could not withstand the strain of this fulminant infection. The autopsy revealed the tragedy of hospital bureaucracy and ignored diagnostic flags: this type of bacteria could have been easily treated.

The final and most incriminating contributing factor is human error. Disregarding the severity of her symptoms and failing to initiate antibiotic therapy in a timely manner cost this child her life. As different physicians noticed nothing was being done, no one deemed this case an emergent stat situation. Busy physicians make mistakes. But does being overworked, understaffed, exhausted, and stressed excuse the loss of life? That is the question that has plagued the medical profession for years.

In medical school we’re taught that every patient deserves to receive the highest standard of care. The physicians involved in this case forgot that simple mantra. Am I naive enough to think I will not make a similar mistake in my practice? No. But the tireless pursuit of perfection is what makes the difference between a good doctor and a great doctor. May I strive to be the latter.
Risk management considerations by Douglas James Heiner

The death of this child is all the more tragic because she was in a hospital, surrounded by medical professionals that could have delivered the highest standard of care. The hospital had all the necessary equipment and was fully staffed with competent medical personnel, many of whom in some way contributed to this failure. Because of the number of medical professionals involved, this case invites a "systems failure analysis" from which much can be learned. Risk management is about managing a "system" to reduce risk. With demands on our medical system exceeding supply, that system must prioritize those patients posing the highest risk and requiring the most expeditious application of system resources.

Appropriate patient prioritization requires: (1) effective communication; (2) clear lines of accountability; and (3) a "back-up" system enabling one professional to immediately challenge another professional's decision that may breach the standard of care or fail to correctly prioritize a patient.

This case involves numerous failures to communicate effectively, e.g., many of the physicians appear unaware that the patient was hospitalized for a similar condition 18 months earlier; Emergency Physician B fails to communicate the urgency of the arthrocentesis; Pediatrician A fails to demand that Orthopedic Surgeon A see the patient when the procedure has not been performed by morning; and Orthopedic Surgeon A fails to communicate to her partner the urgency of the arthrocentesis.

There were also numerous occasions where no physician accepts clear accountability for this patient. Whether Orthopedic Surgeon A refused to come in and perform the requested procedure, there were multiple ways that the tap could have been accomplished: Emergency Physician B could have performed it himself; another affiliated orthopedist could have been called in; or a hospital administrator could have required Orthopedic Surgeon A to respond earlier. Perhaps most surprising is that Pediatrician A did not see the patient until morning, did not require the arthrocentesis to be performed immediately, and failed to frequently evaluate this patient’s condition and demand treatment.

Some circumstances that appear to be failures to communicate may in fact be failures to challenge the poor decision of another professional. Orthopedic Surgeon A decides to “hold off antibiotics” and to perform the arthrocentesis in the morning, over 12 hours after the child is initially admitted to the ER. Emergency Physician B’s failure to challenge these decisions results in a breach of the standard of care for a septic joint which mandates arthrocentesis and early antibiotic therapy with possible surgical debridement. (If the tap could not be completed in a timely way, empiric antibiotics should have been initiated.)

The failures of individual physicians in this case to communicate effectively, accept accountability, or challenge poor medical decisions are “symptoms” of broader system weaknesses that need careful, system-wide improvement to meet the evolving standard of care in a system that is increasingly more sophisticated, complex, and specialized. Although specific improvements are beyond the scope of this brief essay, they are necessary for our extraordinary medical system to deliver the medical “miracles” we all work for.

Risk management considerations by Michael Merrick

This case is an example of poor patient management and inadequate communication. There are a number of ethical dilemmas in this case, and not many of them were handled appropriately. Although the lawsuit that was filed is an important issue to discuss, it is a distant second to the expiration of the 8-year-old girl. A patient’s life was lost because of violations in appropriate care and because inconvenience took precedence over timely management.

The first fault in this case begins with Emergency Physician A’s lack of response to the initial presentation of the patient. It is clear from the patient’s physical exam and striking laboratory values that this was a surgical emergency. The appropriate response before ordering an MRI would have been to immediately contact the orthopedic surgeon. In such a situation, time is of the essence and more than a few hours were lost due to this error in judgment.

The next and most crucial mistake in this case was the decision by Orthopedic Surgeon A to hold antibiotics and wait until the morning to perform an arthrocentesis, and the acceptance of this decision by Emergency Physician B and Pediatrician A. If we assume that the surgeon has no other acute issues to attend to and that she simply made the decision to wait until the morning based on convenience, then this is a completely unacceptable management decision and one that ultimately led to the death of the 8-year-old girl. The physician had the duty of beneficence, to make decisions that were best for the patient’s health. This duty is independent of the hour of the day or convenience of the procedure.

The remainder of the case is an example of the danger of passing on a problem without thorough follow up. Referring a patient to another physician is a completely acceptable practice, even when it occurs within the same specialty. However, there is a responsibility of the referring physician to make certain that the next practitioner is fully aware of the patient’s situation and is capable of providing adequate treatment. In this case we get the impression that Orthopedic Surgeon A informed Orthopedic Surgeon B of a patient’s need for arthrocentesis without adequately explaining the severity of the patient’s condition. This same responsibility falls on Pediatrician A, who is the primary manager of the patient’s medical care. It is the failure of these two physicians that led to the case being settled on their behalf.

The final issue that struck me upon reading this case is the apparent lack of communication with the family. Although not described in detail, the description leaves the reader with the impression that the child’s family was not kept up to date with the medical plan. There are enough mistakes in the care of this patient that better communication with the family may not have had an impact on the family’s decision to file a lawsuit, but the possibility of a better outcome is certainly plausible.
The case presented clearly demonstrates the importance of taking personal responsibility for patient care and the need for a proactive approach to treating patients. As one reads such a case, it is very easy to just focus on the standard of care and to determine on the basis of those standards which physician the blame should be placed upon. However, the more important issue here is whether or not each physician involved has done all he/she could do to provide the best care for the patient. It is, therefore, appropriate to discuss the importance of the physician’s responsibility to patients and the role that a proactive approach to patient care plays in malpractice risk reduction.

Medicine is a field where teamwork plays such a crucial role, and teamwork requires that individual players take full responsibility for their roles. It is evident in this case that several players are involved in the care of the 8-year-old patient: the ER physicians, the pediatrician, and the two orthopedic surgeons. Due to the time limit coupled with heavy patient load, physicians are often tempted to perform the work up accordingly to the standard of care for a specific differential diagnosis and consult the appropriate party without making extra effort to follow up on the patient. In this case, even though the ER physician had already consulted the orthopedic surgeon, he/she has the responsibility of treating the patient accordingly to his/her own clinical judgment instead of waiting and following the orders of Orthopedic Surgeon A, who has not even seen the patient. The same goes for the pediatrician, who should have taken the responsibility for making sure the patient is treated instead of waiting for the orthopedic surgeon to perform the arthrocentesis. Furthermore, the pediatrician should have followed the patient closely to ensure that she is seen by the orthopedic surgeon in a timely manner.

As physicians, we often have to ask ourselves whether or not we have done everything we can for the patient based on what we have available at the moment, that is, taking a proactive approach to patient care. As mentioned above, the time limit coupled with the heavy patient load often tempts the physician to settle for the minimal amount of work on each patient. Every physician, either primary or specialist, should approach each patient as though he/she is the patient’s primary care physician and advocate. This is one of the main principles of teamwork in the health care setting. A proactive approach allows each physician involved in the care of the patient to feel as though he/she is maximizing all options to provide the best care.

Lastly, the importance of proper documentation cannot be ignored, for it forms the cornerstone for all malpractice cases. Without proper documentation, it is often difficult to objectively determine whether the physicians involved have provided the best care for the patient. Without proper documentation, all proactive approaches will not be apparent to the patient, his/her family, and those involved in the litigation. The concept of the physician, whether primary or specialist, taking full responsibility for the patient, a proactive approach to patient care, and the proper documentation of all the steps taken are crucial in evaluating all malpractice cases and are clearly apparent as risk management considerations in the case.
This study is one of many ill-fated examples of how the practice of medicine has become subject to our legal system. Unfortunately, stories such as this exhibit how often physicians are at fault for the adverse fate of a patient. However, as students of our profession, we should learn from these experiences, further our delivery of care and hopefully avoid others’ pitfalls.

Communication is essential to the practice of medicine, especially in today’s age of specialized medicine. This is the principal issue presented in this case. Without details of the physicians’ conversations, it is difficult to assign responsibility, however I speculate that the gravity of the patient’s condition was lost in translation, as her case was shuffled among specialists. The lack of communication is evident throughout this case: Emergency Medicine Physician B did not effectively communicate with Orthopedic Surgeon A; Orthopedic Surgeon A apparently does not know or does not communicate the entire situation to Orthopedic Surgeon B; and Orthopedic Surgeon B claims not to have been informed of the urgency of the situation by Pediatrician A or the nurses. Such failures were implicated in a number of the allegations by the plaintiff. More frequent and explicit communication may have prevented the outcome of this case and would have increased the defensibility of the physicians involved.

As a medical community, we are trained to follow procedures that adhere to a standard of care. In this case, an arthrocentesis should have been performed, followed by the immediate administration of antibiotics. Protocols are followed to ensure adequate care. If Emergency Medicine Physician B believed the patient had a septic joint and that the situation was emergent, he should have consulted another Orthopedist to ensure an immediate arthrocentesis. Since Emergency Medicine Physician B was not trained in performing arthrocenteses and considering the patient’s condition and his apparent concern, another option for Emergency Physician B was to begin antibiotics despite Orthopedic Surgeon A’s advice and the standard protocol. Either of these actions would have corresponded to considering patient safety first and likely would have increased his defensibility.

Defensibility of all physicians involved would be improved with documentation of actions, reasoning, and communication. Not only does this aid in obtaining facts surrounding the case, accountability can be accurately placed. Aside from the aforementioned, I would have initiated antibiotics sooner, whether or not an arthrocentesis had been performed, and I would have followed up despite transfer of care.

Part of becoming a physician is learning one’s limits, capabilities and comfort level. Adapting to situations is essential to the practice of medicine. Orthopedic Surgeon B’s actions surrounding his arrival at the hospital demonstrated the importance of timely adaptation. As an aspiring physician I can take many principles from this case study: communication is essential, protocols are in place to aid in care but treatment sometimes takes precedence over protocol, accurate documentation is a necessity, and honesty should not be avoided for fear of liability.
The diversion dilemma

identifying and preventing prescription drug diversion

Course author
Laura Brockway, ELS is the communications and advertising manager at TMLT.

Disclosure
Laura Brockway 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 1, 2008 and expires on October 1, 2010. Please note this CME activity does not meet TMLT’s discount criteria. Physicians completing this CME activity will not receive a premium discount.

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

1. discuss statistics relevant to prescription drug abuse;
2. identify state and federal requirements for controlled substance prescriptions;
3. describe common drug diversion methods; and
4. list steps that can be taken to help prevent drug diversion.
Prescription drug diversion

An article in the July-August 2008 issue of the Reporter discussed the challenges many physicians face when treating patients with chronic pain. This article will address the related issue of prescription drug diversion. “We have two public health crises going on at the same time: one is undertreating pain and the other is prescription drug abuse . . . As we treat one of those problems and get doctors to treat more aggressively for pain, we’re simultaneously seeing numbers go up related to prescription drug abuse—and no one knows with any certainty if one is driving the other.”

Because many drug diverters have obtained their controlled substances by “doctor shopping” or by feigning symptoms and manipulating physicians, it is important for physicians to learn how to guard against abuse. This article will review statistics on prescription drug abuse, briefly summarize federal and state laws related to prescribing controlled substances, examine common diversion methods, and discuss risk management techniques that can reduce the likelihood that diversion will occur.

Definition

Prescription drug diversion is the channeling of controlled substances or other pharmaceuticals for illegal purposes and abuse. Typical means of diversion include the illegal sale of prescriptions by physicians and pharmacists; “doctor shopping”; theft, forgery, and alteration of prescriptions by patients or health care workers; robberies or thefts from manufacturers, distributors, pharmacies, hospitals, or clinics; residential burglaries; undercounting, pilferage, and recycling by pharmacy personnel; theft of prescription medication by cleaning and repair personnel in homes or hotel rooms; Medicare, Medicaid, and other insurance fraud by patients, pharmacists, and “street dealers”; and by the purchase of prescription drugs over the Internet.

“Moreover, it would appear that pill-abusing middle- and high-school students are obtaining their drugs through medicine cabinet thefts, medication trading at school, and thefts and robberies of medications from other students.”

An article published in the Journal of Pain Symptom Management highlights the problem of diversion through loss or theft from Drug Enforcement Agency (DEA) registrants. In reviewing DEA theft/loss reports from 22 eastern states, researchers found that in 2003, 2 million doses of six Schedule II opioid analgesics—fentanyl, hydromorphone, meperidine, methadone, morphine, and oxycodone—were reported stolen. About 4 million doses of hydrocodone with acetaminophen, the most frequently diverted controlled substance, were reportedly stolen that year. The thefts occurred mostly from retail pharmacies.

“Against the backdrop of a nation conditioned to medicate every ill, the abuse of controlled prescription drugs has gone unattended. Education, prevention, treatment, and enforcement efforts have focused primarily on illicit drugs. Thanks to the Food and Drug Administration (FDA), the medical use of prescription drugs is considered relatively safe. Unfortunately and incorrectly, for too many, this perception extends to their abuse as well.”

Statistics on prescription drug abuse

According to a report published by the National Center on Addiction and Substance Abuse at Columbia University, the most commonly abused prescription drugs include opioids such as oxycodone or hydrocodone with acetaminophen; central nervous system depressants such as diazepam or alprazolam; central nervous system stimulants such as methylphenidate, amphetamine, or dexmethylamphetamine; and anabolic-androgenic steroids such as oxymetholone.

Other facts about prescription drug abuse include the following.

- From 1992 to 2002, the U.S. population increased by 13%. During this time, the number of prescriptions for non-controlled substances increased by 56.6% while the number of prescriptions for controlled substances increased by 154.3%.
- Hydrocodone with acetaminophen has been the most prescribed medication in the U.S. for the last five years, according to an article in the Journal of the American Medical Association. In 2005, more than 100 million prescriptions were written for hydrocodone with acetaminophen, compared with the second and third most prescribed medications—atorvastatin at 63 million prescriptions and amoxicillin at 52 million prescriptions.
- “The number of people who admit abusing controlled prescription drugs increased from 7.8 million in 1992 to 15.1 million in 2003. . this is 23 percent more than the combined number who admit abusing cocaine (5.9 million), hallucinogens (4.0 million), inhalants (2.1 million), and heroin (328,000).”
- 73.8% of prescription drug abusers are poly-substance abusers. They either drink alcohol excessively and/or use illicit drugs in addition to prescription drugs.
- “Abuse of controlled prescription drugs is implicated in at least 23% of drug-related emergency department (ED) admissions and 20.4% of all single drug-related ED deaths.”
- In 2002, opioid analgesic poisoning was listed in 5,528 deaths, more than either heroin or cocaine. A report in a recent issue of Morbidity and Mortality Weekly stated that in 2004, poisoning was second only to motor-vehicle crashes as a cause of death from unintentional injury in the United States. “Nearly all poisoning deaths in the United States are attributed to drugs, and most drug poisonings result from the abuse of prescription and illegal drugs.”
- According to an analysis of U.S. death certificates, deaths from medication errors at home have risen dramatically over the last 20 years. In an article published in the Archives of Internal Medicine, the authors examined all death certificates from January 1, 1983 to December 31, 2004. Of the approximately 50 million deaths, 224,000 involved fatal medication errors, including overdoses and mixing prescription drugs with alcohol or street drugs. From 1983 to 2004 the overall death rate from fatal medication errors increased by 360.5%. The death rate for at-home fatal medication errors that did not involve alcohol or street drugs increased by 564%, while the death rate for at-home medication errors that did involve alcohol or street drugs increased by 3196%. “This increase far exceeds the increase in death rates from adverse effects of medications (33.2%) or from alcohol and/or street drugs (40.9%).”
- Between 1992 and 2003, the number of teens ages 12 to 17 who admit abusing prescription drugs increased by 212%. In 2003, 2.3 million teenagers reported abusing a controlled prescription drug in the past year. Teenagers often “use prescription drugs for ‘practical’ effects: hypnotic drugs for sleep, stimulants to enhance their school performance, and tranquilizers such as benzodiazepines to decrease stress. They often characterize their use of prescription drugs as ‘responsible,’ ‘controlled,’ or ‘safe.’”
Controlling the controlled substances

“Both Texas and the federal government have a complex system of laws governing the availability and dispensing of dangerous drugs and controlled substances. The Drug Enforcement Agency (DEA) is the federal agency and the Department of Public Safety (DPS) is the Texas agency that regulates controlled substances.”

The term “dangerous drugs” includes any drug that requires a prescription and bears the legend “Caution: federal law prohibits dispensing without a prescription” or “Prescription Only.” A controlled substance is a drug with a potential for abuse that may lead to physical or psychological dependence.

The federal Controlled Substances Act (CSA) of 1970 created a system of classifying controlled substances according to their medical value and potential for abuse. These substances, which include both illicit and prescription drugs, are listed in schedules. “Although there are separate provisions under state and federal law describing the drugs that fall within each of the schedules, the definitions are substantially similar.”

“Dangerous drugs” require a prescription, but are not included in the list of scheduled drugs.

Drug schedules in the CSA

Schedule I

These drugs have no currently acceptable medical use and high potential for abuse, addiction, or physical dependence. Examples include marijuana and heroin.

Schedule II

These drugs have accepted medical use and high potential for abuse, addiction, or physical dependence. Examples include morphine, oxycodone, methadone, and hydromorphone.

Schedule III

These drugs have accepted medical use and potential for abuse, addiction, or physical dependence less than drugs in Schedules I and II. Examples include methylenidate, hydrocodone with acetaminophen, and anabolic steroids.

Schedule IV

These drugs have accepted medical use and potential for abuse, addiction, or physical dependence less than drugs in Schedules I to III. Examples include benzodiazepines and chloral hydrate.

Schedule V

These drugs have accepted medical use and potential for abuse, addiction, or physical dependence less than drugs in Schedules I to IV. Examples include codeine-containing analgesics and codeine-containing cough and cold preparations.

Please note that this list is not all inclusive. For a complete list of substances within each schedule, please visit http://www.deadiversion.usdoj.gov/schedules/index.html. To view the Texas schedules, please visit http://www.dshs.state.tx.us/dmd/control_subst_sched.shtm.

Requirements for controlled substance prescriptions

Texas and federal laws require that physicians who prescribe, administer, or dispense controlled substances be registered with the DEA and the DPS. “State and federal controlled substance registrations are interdependent. If the state registration is suspended or revoked, the federal registration may be suspended or revoked, and vice versa.”


The prescription requirements for Schedule II controlled substances are more stringent than those for “dangerous drugs” or Schedule III, IV or V substances. Schedule II requirements include the following.

- A Texas physician who prescribes a Schedule II substance must use an official prescription form issued by the DPS under the Texas Prescription Program. The exception to this rule is for a medication order written for an individual who is an inpatient when the order is written.

- In Texas, as of March 2008, a prescription written for a Schedule II controlled substance must be filled within 21 days after the date the prescription was issued.

New DPS regulations affect Schedule II-V controlled substances

In response to legislation passed in 2007, the DPS will begin collecting additional information on prescriptions for Schedule II-V controlled substances. Beginning September 1, 2008, these prescriptions must contain the following information to be considered valid:

- quantity of substance prescribed (written both as a number and word);
- date of issue (cannot be postdated);
- name, address, and birthdate of the patient;
- name and strength of the drug;
- directions for use of the drug;
- intended use of the drug, unless the physician determines furnishing this information is not in the patient’s best interest;
- printed or stamped name, address, DEA registration number, telephone number of the physician’s usual place of business;
- the physician’s signature unless called into the pharmacy; and
- the physician’s current, valid DPS registration number. For Schedule III-V drugs, the prescriber may be a properly registered physician’s assistant or an advanced practice nurse.

The new law, Senate Bill 1879, was enacted to help reduce prescription drug diversion. “The bill aims to establish an electronic monitoring system for all Schedule II-V drugs that physicians, pharmacists, and others with prescriptive authority can access to monitor their own prescribing patterns and patients who may be using multiple prescribers for narcotics.”

The electronic monitoring system is not yet in place, but the DPS will begin collecting the information on September 1.
Prescriptions for substances on Schedules III, IV, and V may be issued by a physician orally, in writing, or by fax to the pharmacist. A fax is considered to be equivalent to an original prescription. A prescription for a Schedule III, IV, or V drug may be refilled as authorized on the prescription or by call in. However, Schedule III, IV, and V drugs may only be refilled up to five times within six months. After five refills or six months, whichever occurs first, a new prescription is required. 11

The DEA is currently reviewing a petition to increase the regulatory controls on hydrocodone combination products from Schedule III to Schedule II. 14

Other applicable regulations

Electronic prescribing

Currently, prescriptions for controlled substances cannot be transmitted to a pharmacy electronically. “The DEA currently prohibits electronic submission of controlled substance prescriptions, but it is currently working on a system for secure electronic transmission of Schedule II drugs, which it calls the Electronic Prescriptions for Controlled Substances project. All persons authorized to prescribe controlled substances would be issued digital certificates by the DEA, which function as authentication of a practitioner’s authority to prescribe and digitally sign prescriptions for controlled substances.” Guides for the project are being developed, and the DEA is working with the Veterans Administration to test the concept. 15

Tamper-resistant prescription pads

Effective April 1, 2008, physicians were required to use a tamper-resistant prescription pad when writing prescriptions for Medicaid recipients. Effective October 1, 2008, these prescription pads must meet all of the following characteristics in order to be considered tamper resistant under federal law. These characteristics include:

• prevents the unauthorized copying of completed or blank prescription forms;
• prevents erasure or modification of information written on the prescription form;
• prevents the use of counterfeit prescription forms. 16

Also beginning October 1, physician practices that print prescriptions on plain blank paper through electronic medical records (EMR) systems must begin using paper with at least one security feature from each of the three compliance categories listed above. The National Council for Prescription Drug Programs has developed guidance, examples of best practices, and examples of tamper-resistant prescriptions (handwritten and EMR generated), available at http://www.txvendordrug.com/tamper_resistant_rx.html. 17

This regulation does not apply to prescription orders transmitted to a pharmacy by telephone, fax, or electronically. 17

The Centers for Medicare and Medicaid Services has determined that the prescription forms for Schedule II drugs issued by the DPS under the Texas Prescription Program meet the characteristics for tamper-resistant prescribing. “Providers should continue using these pads for all prescriptions for Schedule II controlled substances. These pads should not be used to write prescriptions for non-Schedule II drugs.” 16

Prescription monitoring programs

Texas is one of 26 states that operates a prescription monitoring program. These programs collect prescription data from pharmacies and review and analyze the data for education, public health, investigative, and law enforcement purposes. “States have found that prescription monitoring programs are among the most effective tools available to identify and prevent drug diversion at the prescriber, pharmacy, and patient levels.” 18

In Texas, the DPS manages the state’s prescription monitoring program that tracks prescriptions for Schedule II substances. Physicians who prescribe Schedule II drugs must use official prescription forms issued by the DPS. Pharmacists then transmit records of these prescriptions to the DPS. The DPS securely maintains the prescription records, and access to the information is restricted by state law to regulatory and law enforcement personnel and physicians and pharmacists who are inquiring about patients or potential patients. Physicians and pharmacists can also verify their own prescription records. This information can be requested by completing a form available at http://www.txdps.state.tx.us/criminal_law_enforcement/prescription_program/preform.htm. 12, 18

“Prescription monitoring programs serve as tools that facilitate the locating of evidence with minimal or no intrusion on prescribers and pharmacies. Therefore, the main impact of programs on law enforcement is to provide a mechanism for increased efficiency in conducting investigations.” 18 While both state and federal law enforcement officials believe prescription monitoring programs to be an efficient and effective way to deter diversion, several disadvantages to these programs have been described. 15 “Very few PMPs have been adequately evaluated to determine their impact on the availability of controlled substances for legitimate medical purposes or the subsequent incidence of drug abuse and diversion.” 15

In 2005, the National All Schedules Prescription Electronic Reporting Act (NASPER) was passed. It authorized the creation of federal grants at the U.S. Department of Health and Human Services to establish or improve state prescription drug monitoring programs and allow for communication between state programs.” Unfortunately, NASPER has not moved as no funding has been committed either in 2006 or in 2007, in addition, there is no proposed funding in 2008. 5

Diversion by patients

“Doctor shopping” is one of the most common methods of obtaining prescription drugs for illegal use. “Although it’s important to trust your patients and accept what they tell you at face value, it is also important to maintain a healthy degree of skepticism. Diverters come in many forms, so appearances may be deceptive. Better...
indicators are their behaviors and their stories, which are often similar."  

Strange stories — these can include claims that the patient is traveling through town on business or visiting relatives. Diverters can also claim that they have lost a paper prescription, forgotten to pack their medication, had their medication stolen, or spilled their medication down the sink. These individuals may request to be seen right away or request appointments at the end of the day. 19

Unwilling to cooperate — drug seekers may refuse a physical exam and show no interest in a diagnosis. They may fail to keep appointments for diagnostic testing or refuse to see another physician for consultation. Often, the patient may refuse to sign an authorization to release medical records from a previous physician. “If pressed, they may claim they cannot precisely remember where they were last treated or that the previous clinic, hospital, or provider has gone out of business.” 19

Exaggerated or feigned symptoms — diverters may claim to have back pain, kidney stones, migraine headaches, toothaches, or post-herpetic neuralgia to obtain opioid medications. 19 They may also feign anxiety, insomnia, fatigue, or depression to obtain stimulants or depressants. 4

Specific drug requests — diverters may request a specific medication and state that specific, non-narcotic analgesics do not work or that he or she is allergic to them. “Be alert when patients appear to be extremely well-informed about specific medications. While it is true that people who have been sick for a long time often learn much about their disease process and know the medications that work best for them, this is also true of diverters. They often appear to have a familiarity with diseases that comes straight from textbooks rather than real life. Some diverters may feign naïveté by deliberately mispronouncing medication names or seeming to be uninformed about their underlying medical condition.” 19

In an article published in Pain Medicine, the authors reported on interviews and focus group data collected on four separate populations of prescription drug abusers. The data suggested that there were “numerous active street markets” involving patients. “Many of these individuals have conditions that have been appropriately diagnosed and addressed with a proper course of treatment, but are selling their prescription drugs for profit, or exchanging them for illicit drugs.” 2

A national survey of physicians found that 53.8% do not ask about prescription drug abuse when taking a patient’s health history. Further, 54.5% either always or most of the time call or obtain records from the patient’s previous or other treating physicians before prescribing controlled substances on a long-term basis. 4

“You should contact previous health care providers and pharmacists to confirm the information provided by each new patient. Obtaining the previous providers’ telephone numbers directly from directory assistance or other national sources, rather than from the patients, provides a reasonable assurance that real providers are being contacted (not just confederates of drug-seeking individuals).” 19

In addition to “doctor shopping,” prescription forgery is also fairly common. This can include altering a prescription, stealing blank prescriptions pads, or calling pharmacies for prescriptions without authorization from the physician. 4

Diversion by physician staff

TMLT risk management staff frequently receive calls from physicians who have discovered that an employee is diverting prescription drugs from the office. Typically, this involves an employee calling a pharmacy and ordering a controlled substance under the physician’s signature. Other instances have included staff members creating medical records for fictitious patients and calling in or printing out prescriptions for that patient. “Unpleasant as it is to consider, people who work for you, other physicians, friends, and even family members may be diverting pain medications.” 19

One way to prevent this type of diversion and address it if it occurs is to implement and follow a medication refill policy in the practice. This policy will describe in detail what types of medications can be refilled without a physician’s authorization. “To be effective, these policies must be very specific. They must state who is authorized to refill what kinds of medications and under what conditions,” says Jane Holeman, vice president of risk management at TMLT. “It is also advisable for these policies to state that refills for any controlled substance must be cleared by the physician.”

Once the policy is established, educate staff about the policy and have them sign a copy of it. “This will help protect the physician if it is later discovered that an employee is diverting drugs. The physician can show that the employee was doing so in violation of the practice policy,” says Holeman. Additionally, physicians are advised to state in their employee policies and procedures that any violation of the medication refill policy is grounds for disciplinary action up to and including termination and reporting any diversion to the authorities. While it can be difficult, it is advisable to terminate any staff member who engages in this behavior.

Physicians are often reluctant to report incidents involving prescription diversion by staff to law enforcement officials. However, according to the DPS and the Texas Administrative Code, physicians must report a “discrepancy, loss, or theft of a controlled or other regulated item or substance or other situation involving a potential for diversion” to local law enforcement officials. This includes controlled substances and stolen or forged prescriptions. 20 According to the Texas Controlled Substance Act a person commits fraud if that person knowingly “possesses, obtains, or attempts to possess or obtain a controlled substance or an increased quantity of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge through the use of a fraudulent prescription form or through the use of a fraudulent oral or telephonically communicated prescription . . .” 21

In overcoming their hesitation to report an employee, physicians should also consider the possibility that this person could find employment at another physician’s office or hospital and could continue diverting drugs. “If the employee is not reported, then the incident will not show up on any criminal background check that a potential employer could conduct,” says Holeman. “This person could end up working in the pediatric clinic across town. It is in the best interests of other physicians in the community to report the incident to the police.”

Risk management considerations

The following guidelines may help reduce the likelihood of prescription drug diversion occurring in your practice:

• If you keep controlled substances in your office, be familiar with federal and
state law regarding the storage and disposal of these substances. Follow federal guidelines for monitoring both drug inventory and access to the controlled substance storage area. More information is available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html.

• Follow these same guidelines for samples of controlled substances. Do not keep samples of controlled substances in an unsecured sample closet. “Think about how easy it is for someone to get access to your samples—and that could be a patient, a patient’s child, or a staff member.” 22

• Create and follow a medication refill policy in your practice. Have strict practices in place regarding who can initiate and refill a prescription for a controlled substance. Educate employees about this policy and have them sign a copy of it.

• Develop relationships with pharmacists. “Often it is the pharmacist who first detects a diversion attempt. Divers may try to call in their own prescriptions by claiming to represent a physician’s office and providing his or her personal telephone number for call-back information. A close, working relationship between your office and local area pharmacies may help to prevent these maneuvers from succeeding.” 19

• Make criminal background checks part of the hiring process. According to the DEA Practitioner’s Manual, physicians “should not employ as an agent or employee who has access to controlled substances:
  1. Any person who has been convicted of a felony offense related to controlled substances
  2. Any person who has been denied a DEA registration
  3. Any person who has had a DEA registration revoked
  4. Any person who has surrendered a DEA registration for cause.” 11

• Before prescribing controlled drugs on a long-term basis, obtain the records from the patient’s previous physician. Be wary of any patient who will not sign an authorization to release medical records from a previous physician. Consider asking about prescription drug abuse when taking a patient’s health history.

• If you suspect a patient may be abusing or diverting controlled substances, document your impressions in the medical record. “Document everything you see, think, feel, and hear about the patient without resorting to judgmental or pejorative labels (being mindful that accurate and complete medical records allow subsequent readers or reviewers to understand how you made medical decisions.)” 20 Document any conversations you have with a third party, such as a pharmacist, about your suspicions.

• Consider terminating the physician-patient relationship if a patient is diverting prescription drugs. “While this can be a difficult situation, the physician is putting himself or herself at risk by continuing to prescribe to a patient who has stolen a prescription pad or who is obtaining the same medication from multiple physicians,” says Holman. If you choose to dismiss the patient, follow a standardized process, such as the one described in the May-June 2008 issue of the Reporter (available at http://www.tmlt.org/publications/resources/).

• Do not prescribe, dispense, or administer controlled substances outside the scope of your practice or in the absence of a formal physician-patient relationship.

• Use secure prescription pads. Though federal regulations now require that physicians begin using tamper-resistant prescription pads when prescribing for Medicaid patients, it is also recommended that physicians use these pads (or tamper-resistant printer paper for those using an EMR) for all patients. Be sure to purchase these pads and paper from approved printers. (For a list of approved printers, please visit http://www.texmed.org/Template.aspx?id=6495.)

• Do not store prescription pads in accessible areas, such as countertops or exam rooms. Use prescription pads only for prescribing. Write notes or patient instructions on office stationery. Never sign blank prescriptions in advance.

• Report any theft or significant loss of a controlled substance from a physician’s office to the DEA immediately upon discovery. Notification can be accomplished by completing DEA Form 106, found at www.deadiversion.usdoj.gov. Texas physicians are also required to report theft or loss to the Narcotics Service of the Texas DPS. A DPS form is available at http://www.txdps.state.tx.us/criminal_law_enforce-
ment/prescription_program/preforms.htm or a copy of the DEA form can also be submitted.

• Report any theft of Schedule II prescription pads to the Texas Prescription Service, PO Box 4087, Austin, Texas 78773-0439; (phone) 512-424-2189; (fax) 512-424-5373; (email) tppcsr@txdps.state.tx.us.

• Report any suspected prescription drug diversion by staff or patients to local law enforcement officials.

Conclusion
Physicians have an important role to play in minimizing the abuse or diversion of prescription drugs. “You can do a lot to prevent diversion in your practice by simply maintaining standards of good medical practice and professional ethics. Never prescribe controlled substances to patients unless clinically indicated. Inform patients that it is illegal for you to prescribe opioid analgesics without performing a meaningful physical examination. Follow a protocol of history taking, performing a physical examination and ordering necessary diagnostic tests before prescribing opioid analgesics. And when you or your staff suspect patients of attempting to obtain medications for nontherapeutic purposes or trying to steal prescription pads, notify the local police.” 19

Sources

continued on page 20
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. The most frequently diverted medication is hydrocodone with acetaminophen.
   ○ True
   ○ False

2. From 1992 to 2002 the number of prescriptions for controlled substances increased by
   ○ a. 56.6 percent;
   ○ b. 154.3 percent;
   ○ c. 23.0 percent;
   ○ d. none of the above.

3. Teenagers often abuse and use prescription drugs for
   ○ a. sleep;
   ○ b. a stimulant to enhance performance;
   ○ c. stress reduction;
   ○ d. all of the above

4. The state of Texas operates a prescription monitoring program that is managed by the Department of Public Safety.
   ○ True
   ○ False

5. In a national survey of physicians, the percentage of them not asking about prescription drug abuse in the patient's history was
   ○ a. 50 percent;
   ○ b. 53.8 percent;
   ○ c. 54.5 percent;
   ○ d. none of the above.

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

Physician signature ____________________ Date ____________________

Identifying and preventing prescription drug diversion
CME evaluation form
Please complete the following regarding the article, "Identifying and Preventing Prescription Drug Diversion."
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

Identifying and preventing prescription drug diversion
diversion... continued from page 17


Laura Brockway can be reached at laura-brockway@tmlt.org.

physician impairment... continued from page 4

Sources


Laura Brockway can be reached at laura-brockway@tmlt.org.
Some of the most important information a physician communicates to a patient involves the actions the patient should take after leaving the office. “Get your labwork done as soon as possible.” “Start the medication and come back and see me in two weeks.” “You will need to see a specialist for a definitive diagnosis.” These common phrases may seem straightforward, but do your patients really understand your instructions? 

Unfortunately, research demonstrates that patients often have trouble understanding their physicians’ orders.  
• For a study published in the Annals of Emergency Medicine, researchers interviewed 140 adult, English-speaking patients after their discharge from the emergency department (ED). The patients were asked to rate their understanding of their diagnosis, ED care, post-ED care, and return instructions. Of those interviewed, 78% demonstrated that they did not understand at least one aspect of the ED visit. “These deficits were most common for the category post-ED care, raising significant concerns about the patient’s ability to adhere to discharge instructions and recommendations after leaving the ED.”  
• Research on physician-patient communication has shown that patients remember or understand only 50% of what a physician tells them.  
• An article in Medical Economics points out that when patients do not understand a specialist’s instructions after an office visit, they will often ask their primary care physician for explanation.  
• A Commonwealth Fund/Harvard/Harris Interactive survey of patients with health problems found that “three of 10 respondents in the U.S. (31%) said they left a doctor’s office without getting important questions answered.”  

There are many factors that may account for failure to understand physicians’ orders.  
• Many physicians are overloaded with patients and paperwork. As a result, they may often rush to finish the office visit and may not notice that the patient is confused or does not seem to understand the instructions given during the visit.  
• Patients’ poor health literacy may be an obstacle. Patients with poor health literacy can decrease the quality of health care, increase the cost of health care, and even contribute to medical errors. Patients who do not understand their physicians’ words will likely fail to comprehend the follow-up instructions.  

What can physicians do to ensure that patients understand follow-up instructions? The authors of the ED study proposed one solution called closing the loop (also called teaching back). Closing the loop tests “patients recall immediately after discharge, [or at the end of an office visit] through strategies such as asking patients to repeat information in their own words. . . This technique may improve communication by making physicians aware of comprehension deficits and thereby facilitating individualized patient education.”  

Closing the loop has been shown to improve patient outcomes. In a study published in the Archives of Internal Medicine, the authors observed a group of primary physicians who were treating patients with diabetes mellitus and who had low health literacy. The study found that the physicians rarely tested patients’ comprehension and recall of follow-up orders. But when the physicians did test patients’ recall, the patients experienced improved glycemic control, regardless of the severity of their condition.  

This study also addressed reasons why physicians may not be using a communication strategy such as closing the loop. These reasons include a lack of training, underestimating patients’ information needs, and overestimating their own abilities to communicate the information. “Physicians may also avoid explicitly assessing patients’ recall and comprehension for fear of opening a Pandora’s box and of needing to spend more time with the patient. However, we found that encounters that included an assessment of patients’ recall or comprehension were not longer than those that did not.”  

Closing the loop and improving patient communication can benefit both physicians and patients. “Effective communication can help physicians better manage the demands of modern medical practice. Patients who feel they communicate well with their physicians are more satisfied with their health care, have improved health outcomes, and adhere more frequently to treatment regimens.”  Physicians who effectively communicate with their patients can also reduce the time spent dealing with ineffective treatment and adverse side effects, which can be caused by miscommunication or poor patient comprehension. Because patients often cite interpersonal aspects of care—such as poor communication— as central to the decision to initiate litigation, improving physician-patient communication may also reduce the likelihood of a medical liability suit.  

Sources  
2. Schillinger D, et al. Closing the loop: physician communication—closing the loop. These deficits were most common for the category post-ED care, raising significant concerns about the patient’s ability to adhere to discharge instructions and recommendations after leaving the ED.”  
5. Leidig D. Encourage your patients to Ask 3.  
7. Leidig D. Encourage your patients to Ask 3. the Reporter. May-Jun 2008;  

William Malamon can be reached at william-malamon@tmlt.org
Failure to diagnose temporal arteritis

by Barbara Rose and Dana Leidig

Presentation and physician action

A 68-year-old man came to his family physician several times over a three-week period complaining of body aches, fatigue, weight loss and a continuing headache. Laboratory tests including an erythrocyte sedimentation rate (ESR) were ordered. His diagnosis over three visits included diabetes, viral syndrome, hearing loss, fatigue, headaches, sleep apnea, and insomnia. The patient received B12 and Advil and was told to take a multivitamin daily. Sleep studies were ordered. His ESR was 43.

On May 5, the patient was again seen by the family physician. He reported that he had been to the emergency department (ED) with a severe headache. While there, a CT scan of the head was completed. Although he had been given Lorcal, the headache did not abate. He described the headache as a dull ache at the top of his head and reported that it would awaken him from sleep. He was diagnosed with headaches and insomnia. Laboratory tests were ordered.

The patient returned to the clinic two weeks later with continued headache. An MRI and MRA were ordered. The laboratory results from May 5 showed his ESR was down from the earlier report of 43 to 15. The MRI report described brain atrophy and left mastoiditis, and the MRA report described the cerebral vessels as normal. The patient was referred to a neurologist.

On May 25, the patient saw a neurologist. The patient reported a six-week history of headaches that began one week after he fell from his bicycle and hit the right side of his head on the pavement. He sustained an abrasion in the right frontal temporal region. The patient had not mentioned this fall to his family physician.

The neurologist noted the headache to be a bifrontal temporal occipital headache, much like a cap around the head. There is no history noted of the patient’s ESR or anemia or the patient’s complaints of fatigue, body aches, and jaw claudication. The patient was diagnosed with post-concussion syndrome and was prescribed Fioricet three times a day. He was told to return in one month.

Five days later, the patient returned to the family physician complaining of continued weight loss, decreased appetite, insomnia, and decreased energy. He was prescribed Zoloft. The following week, the patient woke up one morning with loss of sight in his right eye. He saw an ophthalmologist on June 8. The ophthalmologist diagnosed a choroidal infarct and papillitis in the right eye.

He recommended a repeat ESR, a biopsy of the temporal artery, and started the patient on Prednisone. A temporal artery biopsy showed chronic granulomatous inflammation with extensive destruction of the lamina elastica consistent with temporal arteritis.

On June 10, the patient returned to the family physician, who noted that the patient was on Prednisone and was headache free. The patient had no vision in the right eye. This patient was seen at a specialty eye clinic in July where he was diagnosed with irreversible loss of vision in his right eye.

Allegations

A lawsuit was filed against the neurologist and the family physician alleging failure to diagnose temporal arteritis resulting in loss of vision in one eye.

Legal Implications

Plaintiff’s experts asserted that the neurologist failed to meet the standard of care. They were critical of the neurologist’s failure to acquire all of the available medical records and lab reports for this patient from the family physician. With those in hand, he should have been aware of the elevated ESR of 43, the decreased hemoglobin of 12.2, and hematocrit of 36.7 that indicated anemia, which is characteristic of temporal arteritis. The neurologist did not take a complete history of the patient’s symptoms, and he was unaware of the patient’s bodyaches and fatigue. The diagnosis of temporal arteritis was missed and this resulted in loss of vision in the right eye.

Defense experts asserted that the neurologist did not deviate from the standard of care. Temporal arteritis can occur with a normal ESR, and it would be unusual for temporal arteritis to occur with an ESR below 50. The patient did not report any pain localized to either temporal artery. He also had reported his recent head trauma to the neurologist. The defense expert stated that the average neurologist would not order a temporal artery biopsy or start Prednisone based on the patient’s history and the findings in this case.

The defense of this case was complicated by documentation issues. The neurologist’s chart did not include a detailed exam of the head, scalp, and temporal region. He did not document that he ruled out temporal arteritis, though he testified that this was high on his list of possible causes for the headache.

Regarding the actions of the family physician, the plaintiff’s expert stated that the patient’s initial ESR was significantly high and was ignored, the labs were not consistent with a viral infection, and the patient’s anemia was not addressed. Additionally, the headache was never addressed by the family physician with a neurological examination. Defense experts said the family physician took a good initial history and physical and appropriately referred the patient to a neurologist. However, they stated that a patient with several weeks of fatigue, weight loss, and headaches required a thorough work up.

continued on page 24
Failure to stabilize patient before transfer

by Barbara Rose and Laura Brockway

Presentation

A 35-year-old man was involved in a head-on motor vehicle collision. The driver of the car that crossed into the man’s lane of traffic died at the scene. The man and his 11-year-old daughter were seriously injured. It took 45 minutes to extricate the man from his car.

Physician action

The man and his daughter were taken to a local hospital, which had been designated as a Level III trauma center. The man was admitted to the trauma room by a general surgeon at 2:45 p.m. An emergency medicine physician also provided care to this patient. The initial exam revealed that the patient had a heart rate of 120 bpm and a systolic blood pressure of 110 mm Hg. His respiratory rate was in the 30s. The general surgeon noted blood draining from the left ear and multiple lacerations and contusions of the face. An abdominal exam revealed a soft and non-tender abdomen. An open left tibia and fibula fracture with no distal pulses was present. The right tibia and fibula were also fractured, but distal pulses were present.

Despite the fact that he was receiving rapid infusion of saline, the patient’s blood pressure was falling. He was given two units of blood and his blood pressure increased into the 120s. The patient’s mental status continued to deteriorate. Because the patient had symptoms consistent with head trauma, the general surgeon decided that the patient needed to be transferred to a Level I trauma center. This decision was based in part on the fact that they had no neurosurgeon available to treat this patient. At 3:20 p.m., a neighboring hospital was called and agreed to accept the patient. A care flight helicopter was dispatched.

At 3:30 p.m., during the wait for the helicopter, a CT scan of the abdomen, pelvis, and head was performed. According to the radiologist, the results of the head CT were negative, and the abdominal CT was read as follows: “...There is no pneumothorax. No intrahepatic laceration. No definite splenic laceration. A small amount of fluid is suspected about the spleen. There is a small amount of fluid around the omentum. No significant fluid collection in the paracolic gutters, however...There is a small amount of free pelvic fluid and pelvic wall hematoma.” The radiologist reviewed the CT scan with the general surgeon, and both were of the opinion that there was no evidence of internal organ damage or bleeding.

At 4 p.m., the patient’s blood pressure dropped to 69/30 mm Hg. When the care flight helicopter arrived at 4:08 p.m., the patient’s blood pressure had increased to 88/56 mm Hg, and by 4:20 p.m., his blood pressure increased to 120/103 mm Hg. At 4:40 p.m., the care flight helicopter lifted off with the patient, and his blood pressure was 125/34 mm Hg. Three units of blood were administered during flight. At 5:01 p.m., the patient coded while still in the air. CPR was started. The care flight helicopter landed at the hospital at 5:13 p.m., and the patient was brought to the ED at 5:17 p.m. without a pulse or blood pressure. CPR was continued, but the patient did not respond. He was pronounced dead at 5:28 p.m.

An autopsy was performed and the findings included a significant laceration of the patient’s liver and bladder with subsequent hemoperitoneum. The patient was noted to have multiple rib fractures with lung contusions and bilateral hemorhoraces. Approximately 1500 cc of blood was present in the peritoneal cavity as well as 50 cc of blood in both pleural cavities.

The patient’s daughter sustained several bone fractures and a severe scalp wound. She was treated at the Level III hospital and recovered from her injuries.

Allegations

A lawsuit was filed against the general surgeon. The allegations included:

• failure to perform peritoneal lavage;
• failure to properly monitor the increasing hardness of the patient’s abdomen;
• failure to perform a laparotomy to determine the nature and extent of the patient’s bleeding and repair the bleeding; and
• failure to stabilize the patient prior to transfer.

The emergency medicine physician, the radiologist, and the Level III hospital were also sued.

Legal implications

The plaintiff’s expert, a trauma surgeon, was critical of the general surgeon because he did not clearly stabilize the patient before transfer. He stated that the standard of care requires that a patient with persistent hypotension, tachycardia, metabolic acidosis, and altered mental status with no radiological evidence of intracranial injury be stabilized before transfer. It should be clear in the eyes of the transferring physician that there is no surgical source of bleeding that needs to be controlled before transfer. According to this physician, the defendant should have evaluated the abdomen with a peritoneal lavage. He also stated that a hemoglobin level and a blood gas drawn before transfer would have helped the general surgeon determine if the patient’s condition was worsening. This surgeon also testified that the patient would have survived if the defendant had repaired the bleeding internal organs.

The defense expert and the defendant argued that given the patient’s suspected head injury and compromised vascular supply, it was imperative to transfer the patient since there was no neurosurgeon or vascular surgeon available at the hospital. The plaintiffs asserted that since the results of the head CT came back normal, there was no head injury. This argument was challenged when the plaintiff’s experts conceded that a normal head CT does not rule out a head injury and that a shear type injury to the brain will not show up initially on a CT scan.

The defense also argued that there was no indication that the patient was bleeding internally. This is supported by the negative results from the abdominal CT scan and a documented soft and non-tender abdomen. Though the autopsy clearly showed a lacerated liver and the abdomen had 1500 cc of blood, the defense expert believed this occurred (along with the broken ribs) during vigorous CPR efforts. Additionally, it was also viewed as unlikely that...
failure to stabilize . . . continued from page 23

the patient could have survived three hours (from the time of the collision to the time of cardiac arrest) if a severe liver laceration had occurred at the time of the collision.

With regards to the alleged instability of the patient, there were some low blood pressure readings in the hospital record. Specifically, there is a reading at the time the life flight helicopter arrived of 88/56 mm Hg. However, the flight nurse took blood pressure readings immediately after the patient was on board and the patient’s blood pressure was 127/103 mm Hg. It continued in that range during the flight.

One area of weakness for the defense involved a discrepancy in documentation. An ED nurse documented that the patient had a flat, non-tender abdomen. The general surgeon did not document serial abdominal exams, but testified that he was checking the abdomen and found that there was no distension. A care flight nurse noted “abdomen very obese/distended/firm despite NG w 400cc brown liquid noted from same.” The emergency medicine physician testified and documented on the transfer sheet that the patient was unstable at the time of transfer. According to this physician, the patient was “never completely stable” while at the Level III hospital and he was stabilized as best they could before transfer.

Disposition

The emergency medicine physician and the hospital settled their cases. The case against the radiologist was dropped. The case against the general surgeon proceeded to trial. The jury reached a verdict in favor of the defendant.

Risk management considerations

The jury verdict in favor of the general surgeon validated that the members of the panel believed that he acted in a prudent, reasonable manner.

Barbara Rose can be reached at barbara-rose@tmlt.org. Laura Brockway can be reached at laura-brockway@tmlt.org.

temporal arteritis . . . continued from page 22

Disposition

This case was settled on behalf of the neurologist and the family physician.

Risk management considerations

The medical record is expected to include a chronological diary of a physician’s comprehensive history, assessment, findings, differential diagnoses to confirm or rule out, and the reasons for treatment decisions made. This allows those who review the record to understand the physician’s thinking and treatment choices. Relying on memory may not provide an effective defense in the event of a lawsuit.

A physician’s interviewing skills are frequently challenged as many patients are poor historians. For subspecialists, it is relevant to request all available records and test results from the referring physician as it provides the foundation for the referral and a starting point for the consultant.

Barbara Rose can be reached at barbara-rose@tmlt.org. Dana Leidig can be reached at dana-leidig@tmlt.org.