the Reporter

TMLT
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Advertiser beware

The do's and don'ts of physician advertising

There was a time, not so long ago, when advertising by physicians — beyond listing their name, specialty and contact information — was considered not only unethical but also illegal. The American Medical Association's ban on advertising, which had been formulated in the 19th century, was intended to preserve ethical and professional standards against the "encroachment of distasteful commercialism." [1]

This ban persisted until 1979 when the Federal Trade Commission found that the AMA's ban unreasonably restricted the advertising of its members and denied consumers the opportunity to learn more about physicians' services. The FTC issued an order prohibiting the AMA from any effort to prevent advertising. The AMA appealed the order; and, in 1982 the Supreme Court granted physicians the right to advertise. [1]

Two decades later and we have witnessed a dramatic change in the way physicians advertise their services. According to the FTC, 95 percent of all physicians now engage in some form of paid advertising. [2] And, "advertising" per say, is no longer just a placement in the yellow pages. The Texas State Board of Medical Examiners — the entity that regulates physician advertising in Texas — has adopted a broad definition of physician advertising to include "signs, nameplates, professional cards, announcements, letterheads, listings in telephone directories and other directories, brochures, radio and television appearances, and information disseminated on the internet or web." [3] Anything done to inform or promote the services of a physician can be considered advertising and falls under the jurisdiction of the TSBME.

This article will review the TSBME advertising rules, specifically those related to deceptive advertising and the use of the term "board certified," as well as offer guidelines on how to avoid litigation related to advertising.

Misleading or deceptive advertising

"Truthful advertising not only serves to better educate patients toward a more informed decision and choice regarding their medical care, but also enhances competitiveness among providers. The key word here, however, is 'truthful.' Truth in advertising, however, must be verifiable since false, misleading or deceptive advertising is not only unethical but also illegal and subject to sanctions by both the

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Federal Trade Commission and the Texas State Board of Medical Examiners, as well as lawsuits by patients." [4]

The TSBME rules state: "No physician shall disseminate or cause the dissemination of any advertisement that is in any way false, deceptive, or misleading. Any advertisement shall be deemed by the board to be false, deceptive, or misleading, if it:

1. contains material false claims or misrepresentations of material facts which cannot be substantiated;
2. contains material implied false claims or implied misrepresentations of material facts;
3. omits material facts;
4. makes a representation likely to create an unjustified expectation about the results of a health care service or procedure;
5. advertises or assures a permanent cure for an incurable disease;
6. compares a health care professional's services with another health care professional's services unless the comparison can be factually substantiated;
7. advertises professional superiority or the performance of professional service in a superior manner if the advertising is not subject to verification;
8. contains a testimonial that includes false, deceptive, or misleading statements, or fails to include disclaimers or warnings as to the credentials of the person making the testimonial;
9. includes photographs or other representations of models or actors without explicitly identifying them as models and not actual patients;
10. causes confusion or misunderstanding as to the credentials, education, or licensure of a health care professional;
11. represents that health care insurance deductibles or copayments may be waived or are not applicable to health care services to be provided if the deductibles or copayments are required;
12. represents that the benefits of a health benefit plan will be accepted as full payment when deductibles or copayments are required;
13. states that a service is free when it is not, or contains untruthful or deceptive claims regarding costs and fees. If other costs are frequently incurred when the advertised service is obtained then this should be disclosed. Offers of free service must indeed be free. To state that a service is free but a third party is billed is deceptive and subject to disciplinary action;
14. makes a representation that is designed to take advantage of the fears or emotions of a particularly susceptible type of patient;
15. advertises or represents in the use of a professional name, a title or professional identification that is expressly or commonly reserved to or used by another profession or professional;
16. claims that a physician has a unique or exclusive skill without substantiation of such claim;
17. involves uninvited solicitation such as door to door solicitation of a given population or other such tactics for "drumming" patients; or
18. fails to disclose the fact of giving compensation or anything of value to representatives of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement, article, or infomercial, unless the nature, format or medium of such advertisement makes the fact of compensation apparent." [4]

Board certification

The TSBME has also established rules regarding the use of the term "board certified" in advertising. These include:

" (a) A physician is authorized to use the term 'board certified,' or any similar words or phrase calculated to convey the same meaning in any advertising for his or her practice if the specialty board which conferred the certification and the certifying organization meet the requirements in paragraphs (1)-(2) of this subsection:

(1) The certifying organization is a member board of the American Board of Medical Specialties, or the Bureau of Osteopathic Specialists, or is the American Board of Oral and Maxillofacial Surgery; or

(2) The certifying organization requires that its applicants be certified by a separate certifying organization that is a member board of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists, or appropriate Royal College of Physicians and Surgeons, and the certifying organization meets the criteria set forth in subsection (b) of this section.

(b) Each certifying organization that is not a member board of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists must meet each of the requirements set forth in paragraphs (1)-(5) of this subsection:

(1) the certifying organization requires all physicians who are seeking certification to successfully pass a written or an oral examination or both, which tests the applicant's knowledge and skills in the specialty or subspecialty area of medicine. All or part of the examination may be delegated to a testing organization. All examinations require a psychometric evaluation for validation;

(2) the certifying organization has written proof of a determination by the Internal Revenue Service that the certifying board is tax exempt under the Internal Revenue Code pursuant to Section 501(c);

(3) the certifying board has a permanent headquarters and staff;

(4) the certifying board has at least 100 duly licensed certificants from at least one-third of the states; and

(5) the certifying organization requires all physicians who are seeking certification to have satisfactorily completed identifiable and substantial training in the specialty or subspecialty area of medicine in which the physician is seeking certification, and the certifying organization utilizes appropriate peer review. This identifiable training shall be deemed acceptable unless determined by the Board of Medical Examiners to be inadequate in scope, content, and duration in that specialty or subspecialty area of medicine in order to protect the public health and safety.

(c) A physician may not authorize the use of or use the term 'board certified' or any similar words or phrase calculated to convey the same meaning if the claimed board certification has expired and has not been renewed at the time the advertising in question was published or broadcast.

(d) The terms 'board eligible,' 'board qualified,' or any similar words or phrase calculated to convey the same meaning shall not be used in physician advertising.

(e) A physician's authorization of or use of the term 'board certified', or any similar words or phrase calculated to convey the same meaning in any advertising for his or her practice shall constitute misleading or deceptive advertising unless the specialty board which conferred the certification and the certifying organization meet the requirements in subsections (a) and (b) of this section.

(f) A physician who is board certified by an organization that does not meet the requirements set out in subsections (a) and (b) of this section, or otherwise has a special interest in a particular field of medicine, may include in advertisements the physician's field of interest. For each area of interest advertised the physician must clearly state in the advertising "Not certified by an organization recognized by the Texas State Board of Medical Examiners." This statement must be separate and apart from other statements and shall be displayed conspicuously with no abbreviations, changes, or additions in the quoted language so as to be easily seen or understood by an ordinary consumer." [4]

Risk management considerations

According to the TSBME, the most common advertising violation is stating that the physician is board certified when he or she is not board certified as defined in Rule 164. The typical resolution for these violations is a fine and requiring the physician to change the ad.

Advertising can become an issue in malpractice litigation. Recent examples include a patient who underwent sympathectomy for hyperhydrosis and experienced severe compensatory sweating. The patient claimed that it was the surgeon's advertisement in a magazine that triggered his interest in the procedure and brought him to the surgeon. Another case involved a hospital web site's claim that all its physicians were board certified. The discovery that one prominent physician was not board certified triggered a number of lawsuits.

According to Jane Holeman, vice president of risk management at TMLT, certain types of advertising have the potential to create unjustified and misleading expectations in prospective patients. "In many cases, it is difficult enough to defend against the known risks of procedures, much less the subjective promises made in advertising or on the physician's web site," says Holeman. "A plaintiff's attorney will not hesitate to make this an issue in a case, especially if the advertising minimizes risk and promises results that are currently unachievable."

"Physicians must also be aware that the TSBME rules apply to their web sites. This is a problem area for a lot of physicians. The text and graphics on a physician's web site are just as likely to create unrealistic patient expectations as a full-page ad in the yellow pages," says Holeman.

Physicians can consider the following guidelines to help reduce liability related to advertising.

- Become familiar with the TSBME's rules for physician advertising. "It is the responsibility of each physician to carefully scrutinize his advertisements [and web site] and adhere to the highest ethical standards of truth in advertising." [3]
- Avoid making any guarantees or using any language that may inadvertently cause you to be held to a higher standard of care.
- Avoid subjective terms such as beautiful, slim, young, completely cured.

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How to say it

Sample ad and web text

To illustrate how the TSBME rules and ethical guidelines can be applied, we have created advertising/web copy for two fictional practices.

Anywhere Pediatrics

Questionable — "My daughter has never been healthier since seeing the physicians at Anywhere Pediatrics." This testimonial quote most likely does not reflect the overall experience of your patients, and its use should be avoided.

Better — If you use patient testimonials, use them to describe objective, verifiable services, such as extended office hours or walk-in services. "I really appreciate the convenience of the walk-in sick clinic hours." or "There is always plenty of free parking at Anywhere Pediatrics."

Questionable — "All our pediatricians are board certified." This statement is questionable because it is non-specific. The reader may believe that all the physicians are board certified in pediatrics, when in fact two may be board certified by the American Board of Pediatrics and one may be board certified by the American Board of Family Practice

Better — "All our physicians are board certified by the American Board of Pediatrics."

Questionable — "We offer the best pediatric care in Anywhere, Texas." If you are the only physicians in town treating children, it may be permissible to say this. But keep in mind that the family physician across the street and the walk-in clinic at the hospital may also treat children.

Better — "Thank you for trusting Anywhere Pediatrics to take care of your child's needs. You have chosen professionals with special interests in the health and well being of your child."

Anywhere Plastic Surgery

Questionable — "Trust our surgeons to make you look younger and more beautiful. Cosmetic surgery delivers coveted results. The idea of having the body you have always dreamed of is exhilarating." Avoid making promises that cannot be fulfilled. Unrealistic patient expectations can lead to dissatisfied patients and increase exposure to lawsuits.

Better — "A facelift may make you look younger, but it cannot give you a totally different look, nor can it restore the health and vitality of your youth. Before you decide to have surgery, think carefully about your expectations and concerns and discuss them thoroughly with your surgeon."

Questionable — "There has never been a better or safer time to consider cosmetic surgery. Complications from these procedures are rare and cannot cause permanent damage." It is difficult to defend claims in which promotional materials minimize the potential complications from a procedure.

Better — "Dramatic as the end results can be, this is not a simple procedure. Complications can occur, and the estimated recovery time is a week to 10 days."

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• "Testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive." [5]

• Claims regarding the experience, competence and the quality of physicians should only be made if they can be supported by facts. Generalized statements of patient satisfaction should only be made if they are representative of all patients.

• "It is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible." [5]

• Uninvited solicitation, solicitation of a certain population or other tactics for "drumming" patients — is prohibited by the Medical Practice Act of Texas. [4]

• Advertising must be clearly and conspicuously identified as advertising. This includes articles that appear in "special advertising sections" of magazines or newspapers.

• The promotional use of before and after photos that use different lighting, poses or other photographic techniques to misrepresent results can be difficult to defend.

• "It is within the realm of possibility that advertising can be both legal yet unethical. Because of some patients' positions of vulnerability they may be unduly influenced by advertising that is perhaps legal but unethical since it may direct them to use the advertised services to their detriment rather than betterment. Under these circumstances it is a physician's duty to adhere to a higher standard in advertising so that no undue influence is placed on any patient." [3]

Sources

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3. Texas State Board of Medical Examiners. Statement of ethical advertising. Texas Medical Board Bulletin. Fall/Winter 1994. Available at www.tsbme.state.tx.us/guidelines/sea.htm. Accessed on Dec. 1, 2004.
4. Texas State Board of Medical Examiners. Physician advertising Chapter 164.1-164.5. Available at www.tsbme.state.tx.us/ rules/rules/164.htm. Accessed on Dec. 1, 2004. TSBME rules have been established under the authority of the Medical Practice Act, Tex. Occ. Code Ann. section 153.001 and the Health Professions Council, Tex. Occ. Code Ann. section 101.201.
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In case you missed it . . .

HIPAA compliance deadline approaches

April 20, 2005 is the compliance deadline for the HIPAA Security Rule, the third piece of HIPAA legislation to be implemented by health care practices. Now is the time to review each of the security requirements, determine and document your compliance level, and formulate a plan to accomplish compliance. The HIPAAdvisory web site offers the following overview of tasks to be completed before the deadline.

1. Formally appoint an Information Security Official to lead your project.
2. Create a team to complete the tasks.
3. Perform a HIPAA gap analysis to look at the standards and document your current compliance level.
4. Create an inventory of all systems that maintain electronic PHI within the office.
5. Perform an evaluation of each system to determine HIPAA compliance.
6. Begin risk analysis to identify all reasonable risks and vulnerabilities to the confidentiality, integrity, and availability of electronic PHI.
7. After vulnerabilities have been identified, determine what actions need to be taken to reduce or remove the risk.
8. Create an action plan to implement the recommended safeguards.
9. Create policies to guide the practice for each of the HIPAA standards (there are 54 standards).
10. Implement the safeguards.

Remember to document and retain all of your remediation activities for at least six years. For more information visit the HIPAAdvisory website at www.hipaadvisory.com.

TMLT announces spring seminar dates

TMLT's spring risk management seminar "Worst case scenario: surviving and thriving in a medical practice" will be offered in seven Texas cities in April. This seminar is intended for nurses, office managers, front office staff, and medical records personnel. Dates and cities include:

- Tuesday, April 5 — San Antonio;
- Thursday, April 7 — Lubbock;
- Tuesday, April 12 — Austin;
- Thursday, April 14 — Rancho Viejo;
- Tuesday, April 19 — Houston;
- Wednesday, April 20 — Houston;
- Tuesday, April 26 — Tyler; and
- Thursday, April 28 — Fort Worth.

The seminar will address medical records, the treatment of minors, staffing issues and office processes.

Registration begins at 1 p.m., and the seminar time is 1:30-4:30 p.m. Registration fee is $50 for TMLT policyholders and $75 for all others.

Registration materials will be mailed soon. For more information, please contact Natalie Gilmore, 800-580-8658, ext. 5911 or natalie-gilmore@tmlt.org.

ethics exchange

What to tell a patient's wife

This article is the first in a series of articles featured in the Reporter *addressing the ethical concerns of physicians. "Ethics exchange" will present an actual case and will analyze the issues by soliciting the opinions of experts in health law and medical ethics. The opinions expressed in "Ethics exchange" reflect the views of the authors and do not constitute official policy statements of Texas Medical Liability Trust.*

Readers are invited to submit their own cases involving an ethical dilemma for consideration and publication in "Ethics exchange." Cases can be sent to laura-brockway@tmlt.org. The names, addresses, and affiliations of individuals whose cases are used will not be published.

Scenario

Mr. Smith is a 62-year-old man who came to his primary care physician with complaints of rectal bleeding for two days. His medical history includes coronary artery bypass graft, ischemic cardiomyopathy, automatic implantable cardioverter-defibrillator, hypertension, and diabetes.

Vital signs and the results from the abdominal examination were normal. Bright red blood was present on rectal digital examination. A stat CBC was ordered, but due to a miscommunication the patient left the office before the results were available. Because of a decrease in hemoglobin from baseline of 13 grams to 11.5 grams, the physician arranged for a GI consultation and colonoscopy that same day.

Mr. Smith is retired and does not have a cell phone. When the physician called Mr. Smith to inform him of his appointment for that afternoon, his wife answered the home telephone, and reported that Mr. Smith was not at home. Mrs. Smith had never met her husband's physician, and it quickly became clear that Mrs. Smith was unaware of his doctor's visit that day. She was also unaware that he had any acute medical problems. Mrs. Smith became alarmed and demanded to know what was wrong with her husband. The physician's general attempts at reassurance were unsuccessful, and she became more agitated. In order to calm her down and gain her cooperation, the physician informed her that Mr. Smith had some rectal bleeding and that he needed a colonoscopy. She was then able to cooperate and locate the patient.

In this case, the physician had not previously obtained oral or written permission allowing disclosure of privileged health information to the patient's wife. However, there seemed to be no reasonable alternative but to divulge privileged information to Mrs. Smith in order to locate her husband in a timely fashion. Can we reconcile the HIPAA privacy regulations with this physician's breach of confidentiality in order to contact this patient?

Reply by Celeste Lira, RN, JD, a health law attorney and partner with the law firm of Brin & Brin, PC, in San Antonio

Although HIPAA laws may seem overwhelming, they were designed to protect and enhance the rights of patients. The purpose of the regulations is to ensure that only the right people hear and/or see the patient's health information.

These are the HIPAA basics: a patient's health information may be used or disclosed only to the patient or to others for the purpose of providing treatment, obtaining payment or conducting the day-to-day health care operations of the practice. [See 45 CFR 164.502(a)(1).] The HIPAA guidelines address communication with patients at their home and allow for this whether by mail or phone. HIPAA does not prohibit the provider from leaving a message on a patient's answering machine or leaving a message with a family member or other person who answers the phone when the patient is not at home. The message is a request that the patient contact the physician. The health care professional must take care to limit the amount of information disclosed. In the event of an emergency, the provider may disclose protected health information as necessary to provide treatment to the patient. [See 45 CFR 164.522 (a)(1)(Aiii).]

The patient can agree to disclosure orally or in writing. [See 45 CFR 164.522(a)(1).] Many offices have addressed the issue of sharing information with family members by including a simple question on the office intake sheet: i.e. "In the event we cannot contact you directly, please list those persons or family members with whom we should not disclose your health care information."

Reply by Jeffrey P. Bishop, MD, MA, associate professor of internal medicine and director, Ethics in Science and Medicine Program, University of Texas Southwestern Medical Center-Dallas

One area of concern in this situation is that HIPAA regulations assume that the doctor-patient relationship is just another contractual relationship. The doctor-patient relationship is unique and cannot be defined by a legal contract. It would be a travesty if, out of fear of lawsuits and HIPAA fines, physicians automatically approached spousal interactions with suspicion and fear of being sued. If you treat the caring spouse of a patient as if she is merely a contractual partner, you will come across as aloof at best, and antagonistic at worst. And, if things go sour, this kind of antagonistic relationship may increase chances of a lawsuit in the event of a bad outcome.

In our example the "unauthorized" disclosure of information to Mrs. Smith grew out of a certain amount of urgency. That urgency itself was born out of care and concern for Mr. Smith's welfare, and the physician's responsibility to ensure the best possible outcome for his patient. A physician should not have to choose between complying with HIPAA regulations — which may appear to be in conflict with his or her best judgment — and providing for the welfare of patients.

The case presented here was not strictly an emergency at the time of the office visit. The patient's vital signs were normal and the decrease in hemoglobin from baseline was relatively small. At the same time, this elderly patient with ischemic cardiomyopathy might quickly become unstable. The disclosure of a minimum amount of information to Mrs. Smith in order to obtain her cooperation in this potentially urgent setting could be viewed as a reasonable and appropriate option.

Summary by Howard Marcus, MD, FACP, general internist, Austin

Both Dr. Bishop and Ms. Lira caution that since it was apparent that Mrs. Smith was unaware of her husband's appointment (and presumably the reason for making it) the physician should attempt to avoid releasing

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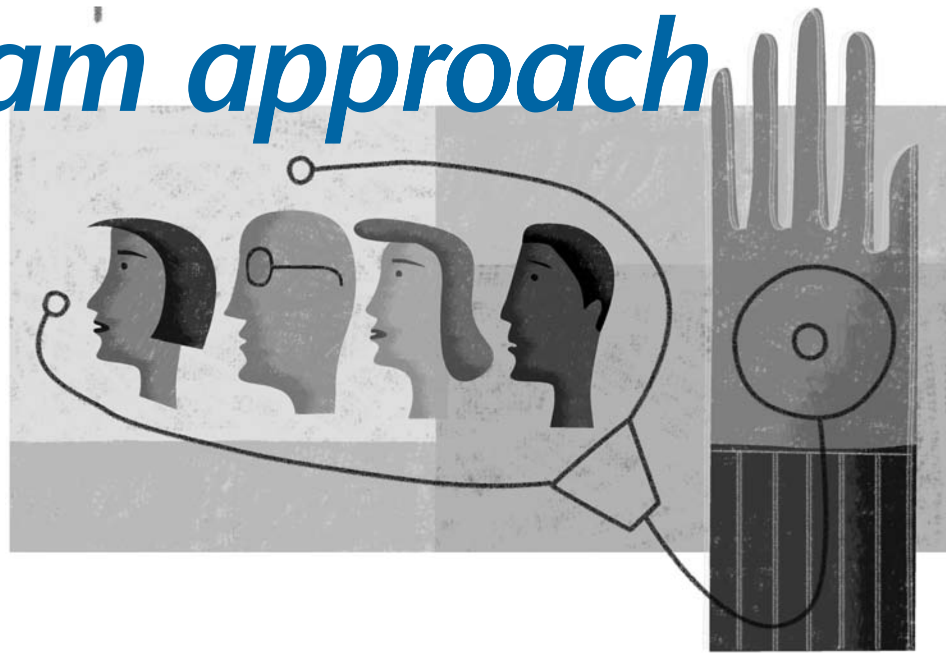
A team approach



Working with advanced health practitioners

Objectives

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

1. Describe the licensing, scope of practice and supervision requirements for physician assistants and advanced practice nurses.

2. Identify the benefits of working with advanced health practitioners.

3. Recognize the liability issues associated with the employment of advanced health practitioners.

Course author

Stacey Agnew is the manager of risk management at TMLT.

Disclosure

Stacey Agnew 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

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 1 category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent 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. In order 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. 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 one hour to read this article and complete the questions.

Release/review date

This activity is released on February 1, 2005, and expires on February 1, 2007. Please note this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Introduction

The use of advanced health practitioners (AHPs) has increased in a variety of medical settings. Also called "mid-level practitioners," "physician extenders," or "non-physician clinicians," AHPs provide care in a variety of medical settings such as solo or group practices and hospitals. AHPs include physician

assistants (PAs), and advanced practice nurses (APNs) which also include other classifications such as certified nurse midwives (CNMs), clinical nurse specialists (CNSs) and certified registered nurse anesthetists (CRNAs). This article primarily focuses on PAs and APNs and the issues that generate potential liability for the physicians who supervise them. (Please note: this article will use the term advanced practice nurse or APN for any reference to a nurse practitioner.)

Over the past decade, changes in training, state laws, regulations, and reimbursement have led to the growth of the AHP professions. According to the American Academy of Nurse Practitioners, it is estimated that there are approximately 106,000 APNs in the U.S. [1] Each year, 5,000 to 6,000 APNs graduate and it has been predicted that in 2005 there will be approximately as many APNs as family physicians in the U.S. [2] The Board of Nurse Examiners for the State of Texas (BNE) indicates that as of September 1, 2004, there were 5,532 APNs in Texas.[3] The American Academy of Physician Assistants estimates there will be approximately 55,000 PAs in clinical practice in the U.S. in 2005. In Texas, there are 3,365 PAs practicing as of January 1, 2005. [4]

Physician assistants

In the mid-1960s physicians and educators identified a shortage of primary care physicians. Duke University Medical Center put together the first class of PAs in 1965. The class was made up of navy corpsmen who received considerable medical training during their military service and during the Vietnam War, but who also had comparable civilian employment. The curriculum was based on the fast-track training of doctors in World War II. [5]

The American Academy of Physician Assistants defines PAs as "health care professionals licensed to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventative health care, assist in surgery, and in most states can write prescriptions."

PAs are educated in intensive medical programs accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). The average program curriculum runs 26 months, and there are currently more than 130 accredited programs. Education consists of classroom and laboratory instruction in the basic medical and behavioral sciences such as anatomy, pharmacology, pathophysiology, clinical medicine, and physical diagnosis. Clinical rotations include internal medicine, family medicine, surgery, pediatrics, ob-gyn, emergency medicine, and geriatric medicine. [6]

PAs are found in all specialties, including family practice, internal medicine, ob-gyn, pediatrics, and in surgery and surgical subspecialties. [6]

Licensure

The State Board of Physician Assistant Examiners (SBPAE) regulates PAs in Texas. To obtain a license in Texas, the candidate must:

- graduate from an accredited program;
- have a valid and current certificate issued by the National Commission on Certification of Physician Assistants (NCCPA);
- be subject to a rigorous background check;
- indicate the supervising physician through the Notice of Intent to Practice/Supervise a Physician Assistant document from the SBPAE; and
- obtain 40 hours of continuing medical education (CME) per year to maintain license. Of the 40 hours required, 20 must be Category I credit by a CME sponsor approved by the American Academy of Physician Assistants. [7]

Scope of practice

The PA's scope of practice is defined by the SBPAE and the Medical Practice Act:

"The physician assistant shall provide, within the education, training, and experience of the physician assistant, medical services that are delegated by the supervising physician. The activities listed in paragraphs (1)-(9) of this subsection may be performed in any place authorized by a supervising physician, including, but not limited to a clinic, hospital, ambulatory surgical center, patient home, nursing home, or other institutional setting. Medical services provided by a physician assistant may include, but are not limited to:

(1) obtaining patient histories and performing physical examinations;
(2) ordering and/or performing diagnostic and therapeutic procedures;
(3) formulating a working diagnosis;
(4) developing and implementing a treatment plan;
(5) monitoring the effectiveness of therapeutic interventions;
(6) assisting at surgery;
(7) offering counseling and education to meet patient needs;
(8) requesting, receiving, and signing for the receipt of pharmaceutical sample prescription medications and distributing the samples to patients in a specific practice setting where the physician assistant is authorized to prescribe pharmaceutical medications and sign prescription drug orders at a site, as provided by the Medical Practice Act, Chapter 157, and its subsequent amendments, or as otherwise authorized by this Act or board rule;
(9) the signing or completion of a prescription as provided by the Medical Practice Act, Chapter 157; and
(10) making appropriate referrals." [8]

Each PA and supervising physician shall ensure that:

- the PA's scope of function is identified;
- delegation of medical tasks is appropriate to the PA's level of competence;
- the relationship between the PA and the supervising physician and the access by the PA to the supervising physician are defined; and
- a process is established for evaluating the PA's performance. [8]

Supervision requirements

According to the Medical Practice Act, a physician designated as such shall supervise a PA, overseeing the activities of, and accepting responsibility for, the medical services provided by the PA. A PA may have more than one supervising physician. The supervision of a PA must be continuous; however, the supervision does not require the constant physical presence of the supervising physician where PA services are being performed. If a supervising physician is not present, the physician and the PA must be, or must be able to easily be, in contact with one another by radio, telephone, or another telecommunication device. [8]

A supervising physician must:

- hold an unrestricted and active license as a physician in Texas;
- notify the medical board of the intent to supervise a PA;
- submit to the medical board a statement that the physician will supervise the physician assistant according to medical board rule, and retain professional and legal responsibility for the care provided by the PA; and
- receive approval from the medical board to supervise the PA. [8]

Advanced practice nurses

In the same year (1965) that the first PA program was established, the University of Colorado created a pediatric nurse practitioner program. The program was created in the traditional nursing philosophy of total patient care. The push for APNs began along

with a rising demand for medical services, rising health care costs and a shortage of primary care physicians due to greater specialization. [5]

The American College of Nurse Practitioners defines an APN as "a registered nurse with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. A nurse practitioner [APN] provides some care previously offered only by physicians and in most states has the ability to prescribe medications. Working in collaboration with a physician, a nurse practitioner [APN] provides high-quality, cost-effective and individualized care for the lifespan of patient's special needs." [9]

APNs are educated through programs within a college or university that grants either a certificate or master's degree. For those who practice in Texas, the education program must be accredited by the BNE. Before applying to an APN program, it is recommended that the nurse have extensive clinical experience. Key components of most APN programs include an intensive preceptorship under the direct supervision of a physician or an experienced APN, and instruction in nursing theory. [9]

APNs are the largest group of advanced health practitioners and are found in family practice, internal medicine, pediatrics, and ob-gyn. An increasing number of APNs are choosing critical care, emergency medicine, and other specialties. [2]

Licensure

The BNE regulates APNs in Texas. To obtain a license, the candidate must:

- hold a current, valid and unencumbered license as a registered nurse in the state of Texas;
- complete an advanced educational program of study accredited by the board for practice in an advanced nursing specialty and role as recognized by the board;
- programs of study shall be at least one academic year in length and may include a formal preceptorship. As of January 1, 2003, the program of study shall be at the master's degree level;
- complete 400 hours of current practice in last biennium.
- earn 20 contact hours of continuing education in the advanced specialty recognized by the board in order to renew license every two years. [10]

Scope of Practice

As defined by the BNE and the Texas Administrative Code, the APN provides a broad range of health services, the scope of which shall be based upon educational preparation, continued advanced practice experience and the accepted scope of professional practice of the particular specialty area. APNs practice in a variety of settings and, according to their specialty and role, provide a broad range of health care services to a variety of patient populations.

In addition, the scope of practice of particular specialty areas shall be defined by national professional specialty organizations or APN organizations recognized by the board. The APN may perform only those functions within that scope of practice and which are consistent with the Nursing Practice Act, Board rules, and other laws and regulations of the State of Texas. The APN's scope of practice shall be in addition to the scope of practice permitted a registered nurse and does not prohibit the APN from practicing in those areas deemed to be within the scope of practice of a registered nurse. [11]

Supervision Requirements

An APN may act independently and/or in collaboration with other health care professionals. In a collaborative practice, the APN is authorized to diagnose and prescribe under the protocols established by the supervising physician. Consultation with the supervising physicians, or the designated alternate physicians, is available at all times on-site, by telephone or other electronic means of communication when consultation is needed for any reason.

Prescriptive authority laws

In Texas, the rules for prescriptive authority are the same for PAs and APNs. If prescriptive authority is needed, the Physician Designation of Prescriptive Delegation from the TSBME must be filed. The prescriptive authority is delegated by a physician through protocols that are reviewed and signed at least annually. Prescriptive authority must also be site-based, which means the PA or APN can only have prescriptive authority at the qualifying site. A physician may be limited to supervision of three full time equivalent PAs or APNs if prescription authority is included. The TSBME has specific requirements of a supervising physician if the practice site is considered to be in a medically underserved area. This information can be accessed at www.tsbme.state.tx.us/rules/rules/193.htm. [12]

Benefits

The American Medical Association and other allied health organizations agree that the use of AHPs is generally cost-effective, increases quality of care, and may lower the physician's liability risk if the AHP is properly supervised. [13] The benefits an AHP can offer to a practice are numerous.

- Increased access to health care for patients who have the option to be seen by an APN or a PA instead of waiting for an appointment with the physician.
- Patient satisfaction may be enhanced because of reduced waiting time and increased time spent with the caregiver.
- The physician can spend more time with complex cases. AHPs can perform a variety of time-consuming but important tasks, including physical exams, immunizations, blood pressure checks, prenatal visits, wound checks, and treatment of minor complaints such as colds, respiratory infections and minor skin problems.
- Improved communication due to AHP training that focuses on health maintenance, disease prevention, counseling and patient education. AHPs report that patients often feel more comfortable asking them questions rather than the physicians which enhances patient education. [14]
- Revenue for the practice may increase because more patients can be seen each day. [13]
- Documentation may be more thorough, as most AHPs had the importance of documentation emphasized during their training and therefore recognize the value. [14]

Liability issues

The frequency and severity of liability claims associated with AHPs is not easily obtained. However, the Physician Insurers Association of America (PIAA) Data Sharing Project reports a low number of claims involving AHPs. PIAA has collected and reviewed 193,000 claims from January 1985 through December 2002 in which 96,415 "associated personnel" issues were reported. Claims involving PAs totaled 1,345 and those involving APNs totaled 484. [15]

Most lawsuits involving AHPs do not solely involve the PA or APN. The supervising physician may incur vicarious liability exposure for the actions of the AHPs and the alleged lack of supervision. Lawsuits against AHPs include the following allegations:

- providing services beyond their scope of care;
- inadequately performing an exam or history;
- failure to develop and follow protocols;
- failure to consult with the supervising physician, which results in failure to diagnose a condition or a delayed referral to a specialist or diagnostic study; and
- improper medication monitoring or ordering. [13]

Allegations against physicians resulting from the actions or inactions of AHPs are as follows:

- inadequate supervision by the physician;
- failure to establish standardized policies and procedures for the AHP to follow;
- over-delegation of duties by the supervising physician resulting in the AHP practicing beyond his or her scope of care;
- supervising physician signing off on chart entries made by the AHP without thorough review; and
- negligent hiring. [13]

Case study

Presentation

A 32-year-old woman came to her family physician complaining of a lump in her breast. She had no family history of breast cancer. The physician felt a nodule in the left breast. Its presence was charted and its location drawn in the medical record. The physician also charted a recommendation for an ultrasound of the breast.

Three months later, the patient came to the office to be treated for a gum infection, but was unable to see the physician that day. The patient saw the PA, who prescribed antibiotics and referred the patient to a dentist. The order for the ultrasound had not been matched to the medical record, and the PA did not follow up on the breast complaint at that visit.

One month later, the patient returned to the physician complaining of the left breast mass again. The physician unsuccessfully attempted aspiration and charted an order for a mammogram and a referral to a surgeon in his building.

Over the next nine months, the PA saw the patient on five different occasions for treatment of a urinary tract infection, allergic rhinitis, sinusitis, reactive airway disease and neck pain after an automobile accident. No breast exam or follow up on the breast complaint was charted at any of these visits. The patient subsequently went to another family physician for an auto accident injury. That physician referred the patient to a surgeon who diagnosed breast cancer. The breast cancer had spread to her spine, neck, lungs and lymph nodes.

Allegations

A lawsuit was filed against the supervising physician, the PA and the entity in which they were employed. The allegations included:

- failure/delay in diagnosis of breast cancer;
- negligence on behalf of the entity for acts and omissions of employees, including the PA and all non-physician nursing and clerical employees;
- failure to make a surgical referral to have the breast mass biopsied;
- failure to have an ultrasound of the breast performed;
- failure to provide the patient with adequate follow up instructions to comply with referral information in the chart note;
- failure to inform the patient or give her referral information for ultrasound tests and surgical consultation subsequent to her office visits; and
- failure to adequately follow up on referral information when the patient was seen by the PA after the breast mass was noted.

Legal implications

The plaintiff's attorney was able to retain experts in primary care and oncology who were critical of the family physician and the PA. The experts related the patient's Stage IV bone/lung metastases to the 14-month delay in diagnosis. Specifically, the expert stated that if the patient had been diagnosed and treated initially, her cancer would have been localized and treatment would have yielded a 60% to 80% cure rate. Instead she is expected to survive no more than two to three years and has a less than 5% chance for a cure.

Defense consultants concurred that the physician followed the standard of care by initially ordering the breast ultrasound. The patient was noncompliant, failing to obtain the ultrasound, mammogram or the surgical consult. However, the medical records lacked documentation of the follow-up communications with the patient to verify that the ultrasound, mammogram and surgical consultation had been completed. Additionally, the medical record did not reflect the patient's noncompliant behavior.

Disposition

The lack of follow-up with the patient to verify that the breast studies were complete was a weakness on the part of the family physician and the PA. It was believed the patient's cancer progressed due to the 14-month delay in diagnosis and treatment, which resulted in a decreased life expectancy. This case was settled on behalf of the physician.

Risk management considerations

The lack of coordination and communication between the physician and the PA was the most obvious weakness in this case. When multiple providers in a practice see a patient, continuity of care becomes a greater and more crucial challenge. It was evident the physician and PA were not conferring or reviewing the patient's record. The treatment prescribed during each visit was based on the presenting symptoms, and minimal attention was directed to her previous health history. As in any situation where multiple caregivers manage a patient, it is recommended the previous progress notes and health history be reviewed for follow-up issues.

The lack of follow up on the ultrasound and referral to the surgeon was damaging to the PA and her supervising physician. It was later discovered that several conversations had taken place between the physician, the PA and the patient to address the patient's noncompliance; but none of this was documented in the medical record. In a malpractice case, a lack of documentation requires all involved to rely on recollection, which is not viewed as reliable and as objective as a chart note.

Finally, written patient care protocols can assist in defining appropriate actions for staff to follow to prevent important issues from being overlooked. When a written protocol does not exist or the AHP is not aware of it, and their treatment is questioned, it can lead to difficulties in defense. In this case, the PA indicated she was not aware of the process in place to review pending studies. The physician and the AHP should review protocols periodically and make the necessary revisions to ensure the information is current and the process is being followed consistently.

Limiting exposure and risk management

The most prevalent causes of lawsuits against AHPs include: rendering a service beyond their scope of care; taking an inadequate patient health history; failure to consult with the supervising physician — resulting in failure to diagnose a condition; neglecting to refer a patient; failure to follow established protocols; and improperly ordering or monitoring studies or medications. [14]

Developing and following reasonable guidelines for performance and supervision can reduce the liabilities for physicians who employ AHPs. In addition to these guidelines, the following recomendations may help limit exposure to AHP-related lawsuits.

- Before hiring an AHP, review his or her background as thoroughly as you would any physician. Check the applicant's credentials and verify experience, education, licensure, and certification as required by law.
- Review state laws related to licensure, scope of practice, and supervision of AHPs.
- Verify the competence of the AHP through personal observation, chart review, and regular meetings. Document performance before allowing him or her to treat patients.

• Develop written guidelines with the AHP that specify his or her role in examining, assessing, diagnosing, and treating patients. Written guidelines define the supervising physician's role and assist in identifying the situations where referral to the physician is needed. Periodically review and update the guidelines.

• Establish an "open-door" policy that allows AHPs to discuss their questions about treatment and to keep physicians informed about the management of patients.

• Make sure staff members are aware of the AHPs' responsibilities and limitations.

• Consider using a consent form indicating the patient's understanding and agreement to treatment by an AHP. This could be beneficial in the defense of a claim where the patient denies knowing that the caregiver was not a physician.

• As required by licensing boards, when engaged in professional activities, AHPs should wear a nametag identifying their licensure.

• Introduce the AHP to patients and identify his or her specialty and skills. Assure patients that they have the option to be seen by the physician if they desire. Stress that the AHP works collaboratively with the physician and will periodically be evaluated to confirm supervision and collaboration.

• Ask patients about their treatment satisfaction with the AHP.

• Gently correct patients who may refer to the AHP as the "doctor."

• If the AHP will see your hospital patients, get approval from the hospital or have him or her apply for privileges from the hospital's medical staff.

• Introduce the AHP to your on-call partners, and share a copy of the written practice guidelines. When the supervising physician is not on call, delegate supervision to another physician. [14]

• Allow only those who are willing to supervise and who will be supportive of an AHP to have supervision authority. [13]

Conclusion

Patient care responsibilities have increased resulting in the need for additional health care professionals, such as advanced health practitioners. As the number of these professionals rises, the total may soon equal half the number of physicians.[2] Many factors contribute to this growth, including the professional aspirations of those who enter the AHP professions, institutional goals of the schools that offer training programs, and the changing health care environment. In addition, physician practice dynamics have changed, resulting in shifts from solo to group practices and vice versa. Many routine procedures once performed only by physicians are now being performed by PAs and APNs. Overall, the use of AHPs is cost effective and is met with a high degree of satisfaction for both physicians and patients.

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In Memoriam: Martin F. Scheid, MD

Dr. Scheid, a Houston surgeon and former chairman of the TMLT Board of Governors, passed away in the fall of 2004. In addition to serving as chairman, Dr. Scheid also served as vice chairman and secretary-treasurer of the TMLT Governing Board. He had been a member of the TMLT Claims Review Committee since 1979 and was chairman of that committee.

Dr. Scheid practiced surgery for more than 40 years, after receiving his medical degree from The University of Texas Medical Branch at Galveston in 1957. He was an active member in the medial community, representing many groups. Dr. Scheid was a member of the Southwest Surgical Congress, the Houston Surgical Society, the American College of Surgeons, the American Board of Surgeons, the Harris County Medical Society Executive Board, and the Harris County Medical Society Board of Ethics. He was past chief of staff and a member of the governing board of Heights Hospital; past president of the Houston Academy of Medicine; and co-founder of the Impaired Physicians Committee of Harris County Medical Society.

Dr. Scheid's dedication and leadership in the surgical community will not be forgotten and he will be missed by his family, friends, and colleagues.

CME test questions

Instructions: Using black ink, read each question, select the best answer, and then clearly mark your selection. Please fax the completed test to the risk management department, attention Rebecca Deones 512-425-5996. You can also mail the test to the TMLT risk management department, attention Rebecca Deones, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide below.

1. Advanced practice nurses include:
   a. clinical nurse specialists b. certified registered nurse anesthetists c. certified midwives d. a, b, and c

2. Most lawsuits involving advanced health practitioners do not involve physicians.
   a. true b. false

3. The number of CM
   a. 20 hours per yea

4. A physician may be ... on authority is included.
   a. true

5. Allegations against ... ude:
   a. inadequate supe ... d. both a and c

CME evaluation for

Please complete the f

1. The objectives for t

2. The material will b

3. Did you perceive a ☐ Yes ☐ No

4. How long did it ta ☐ 1.25 hrs

5. On a scale of 1 to 5
   the effectiveness o ☐ 4 ☐ 5

6. What will you do

____

7. Suggestions for co

____

Expired CME

8. Suggestions for future topics include:

____

____

Contact information

Name ____________________ Phone ____________________

Address ______________________________ TMLT policyholder? ☐ Yes ☐ No

Email address (to have your certificate emailed) *Please print legibly. We cannot email your certificate if we cannot read your email address.*

Know a deserving student?

TMLT Memorial Scholarships

TMLT is pleased to announce the creation of the TMLT Memorial Scholarships, which will recognize academically gifted Texas medical students who are interested in finding creative ways to enhance patient safety. TMLT will award eight $5,000 scholarship annually, beginning in September 2005.

To be eligible for the scholarship, applicants must:

- be entering their third or fourth year of study at a Texas medical school;
- have a minimum, cumulative GPA of 3.0
- be able to demonstrate financial need;
- be able to communicate his or her commitment to patient safety and medical risk management through an essay.

To apply for the scholarship, students must submit the following:

- an application (available at www.tmlt.org)
- a medical school transcript;
- a brief statement of personal financial need; and
- a 1,000 word essay answering the question: What can individual physicians do to ensure patient safety and minimize the risk of medical malpractice suits?

All application materials will be available on the TMLT web site February 15, 2005.

One student from each Texas medical school will be awarded a $5,000 scholarship. The winners will be chosen in a competitive process based on a point system that weighs each student s academic achievement, financial need and essay. Winners names and essays will be published in *the Reporter* and on the TMLT web site.

The application deadline is June 1, 2005.

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closed claim study

Failure to report differential diagnosis, issuing a misleading report

by Barbara Rose and Laura Brockway

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation

A 68-year-old man came to his family physician with complaints of a "several month" history of worsening memory, confusion, difficulty sleeping and intermittent problems with his left hand and arm becoming weak and numb.

Physician action

The family physician suspected TIAs, but wanted to rule out brain cancer. He ordered a CT scan of the head and arranged for a carotid ultrasound. The family physician completed the order form for the CT, requesting the CT to rule out brain cancer, but noted possible TIAs. He also included the patient's symptoms on the form, and asked that the patient's medical records be forwarded to the testing facility.

The family physician's nurse called the hospital to set up the CT scan. She later testified that she read the request from the family physician as "R/O brain cancer." The billing clerk at the hospital changed that to read "R/O METS." This information was then sent to the hospital's radiology technician who changed it from "R/O METS" to "METS" because "R/O METS" did not fit the Medicare codes.

When the radiologist received the request, the clinical diagnosis was "METS." None of the family physician's suspicions or medical records noting "TIAs, organic brain syndrome, or mental status changes," were forwarded to the radiologist. The CT scan was performed with and without enhancement. In the initial portion of the radiologist's report, he noted that what he saw was "consistent with metastatic disease." Later in his report, he made reference to "this metastasis" rather than "this possible metastasis."

The day after the CT scan, the patient reported to the emergency department at another hospital. His symptoms included dizziness, weakness, memory loss and slurred speech. The ED physician suspected a TIA and administered Heparin. The patient was then admitted to the hospital, under the care of an internal medicine physician. This physician continued the Heparin, ordered a carotid ultrasound, and contacted the radiologist regarding the previous CT scan. The radiologist read the report to the internal medicine physician. At that time, the internal medicine physician decided to discontinue the patient's anticoagulation treatment because it was contraindicated for patients with cancer. The carotid ultrasound was also cancelled.

The internal medicine physician ordered tests to look for the tumor, but the tests failed to find any evidence of cancer. After two days in the hospital, the patient was discharged with a diagnosis of "metastatic brain disease, primary tumor site undetermined," and was referred to an oncologist. Two weeks after he left the hospital, the patient suffered a major CVA. A CT scan and MRI of the head identified multiple areas of infarction with no evidence of metastatic tumor. A carotid flow study revealed total occlusion of the left internal carotid artery. The CVA caused severe paralysis to the left side of the body. The patient is currently wheelchair bound and is unable to speak.

Allegations

A lawsuit was filed against the radiologist, alleging the following:

- failure to report an appropriate, accurate differential diagnosis;
- failure to suggest additional, follow-up radiological studies;
- issuing a misleading and inaccurate CT report of metastasis; and
- failure to clinically correlate the information in the CT report which ultimately led to a failure to diagnose the patient's condition.

The family physician, the hospital where the CT scan occurred, and the internal medicine physician were also named in the lawsuit.

Legal implications

The defendant radiologist was adamant that his interpretation of the CT scan was correct and was consistent with the history provided to him on the radiology request. The statement "METS" led the radiologist to believe that a diagnosis of cerebral metastases had been established, and that he was to report whether brain metastases were present on the CT scan.

Two board certified radiologists reviewed this case and both felt the CT scan was far more suggestive of stroke than brain metastasis. Both radiologists said they would have listed possible ischemia on the differential. The plaintiff's expert, also a board certified radiologist, felt the defendant's read of the CT scan was accurate, but the defendant's final impressions were incorrect because he did not list ischemic disease as a possible differential diagnosis. TMLT was able to find an expert supportive of the radiologist's diagnosis, but this expert did not come across as a very strong witness at deposition.

The case against the radiologist was weakened by testimony from the co-defendant physicians and their experts. They all testified that it was within the standard of care to rely on the radiologist's review of the CT in deciding to discontinue the patient's anticoagulation treatment.

This case was further complicated by two factors. There was a dispute between the family physician's nurse and the hospital

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Policyholders elect physicians to TMLT Governing Board

Three physicians were elected to open board positions on the TMLT Governing Board. Those elected were:

- Stuart McDonald, MD, pulmonary and critical care medicine, Fort Worth;
- Dave W. Kittrell, MD, obstetrics and gynecology, San Antonio; and
- David G. Joseph, MD, family physician, Austin.

Each new board member will serve a 3-year term. Completing the board term for Dr. Martin F. Scheid, who passed away in 2004, is Jimmy Strong, MD, a pediatrician from Abilene.

Governing board officers will be elected at the January board meeting and announced in the March-April edition of *the Reporter.*

Ethics exchange . . . *continued from page 5*

any additional medical information. What should be communicated to the spouse in the face of her mounting anxiety? The physician should explain that both federal and state privacy laws prohibit the unauthorized release of a patient's clinical information, but that since her husband left the office without being notified about a follow-up appointment that same day, her assistance was needed. By acknowledging their mutual frustration with these legal constraints, the physician can avoid appearing aloof and uncaring. At this point, the spouse's willingness and ability to cooperate should be weighed against the potential benefits of providing her with additional clinical information. In cases where the line between "urgent" and "emergent" may be a matter of hours or days, the physician must assess the risk/benefit of disclosure versus privacy, and the potential harm such disclosure could create for the patient. Finally, the physician's attempt to reach the patient and the discussion with the spouse should be carefully documented in the medical record.

Closed claim study . . . *continued from page 11*

billing clerk over what information was relayed over the telephone about the request for the CT. Regardless of this dispute, the radiology technician changed the diagnosis from "R/O METS" to "METS" and this affected the defendant's review of the CT. Further, when the family physician received the CT report from the radiologist, the admitting diagnosis at the top of the report said "METS." Had this been noted, it may have alerted the family physician to the error.

Disposition

The case against the radiologist was settled during trial. The hospital and family physician also settled. The case against the internal medicine physician was closed without indemnity payment.

Risk management considerations

This claim offers an example of the adage "if it can possibly go wrong, it will." The health care system broke down in many places. What are the lessons to be learned? Physicians need a system to verify that their employees follow orders as directed. The patient's symptoms and medical record information were not on the CT order. It would seem unconscionable that billing clerks and radiology technicians are allowed to alter information and it is assumed they are not. Two more system failures occurred.

Without the clinical history of possible TIAs, cognitive changes and intermittent numbness of the left upper extremity, the radiologist interpreted a CT scan assuming a diagnosis of metastasis. Including differential diagnoses and recommending further studies to rule out or confirm each diagnosis are standard protocols in the practice of radiology. Why was the carotid ultrasound not done? Apparently, it was not ordered at the same time as the CT scan. The nurse did not complete the orders and the family physician did not determine the oversight.

Hindsight reveals numerous system failures in a complex health care industry that contributed to this tragic event.

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