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interviewers — journalists — for ideas that may help make the physician-patient interview more effective.

The journalistic method

“Journalistic interviewers are not equal: Some get more than others. They do it not by clever questions or intimidating tactics. Quite the opposite. They get more by asking fewer questions, listening more intensely, and responding to what they’ve heard.”²

Both physicians and journalists have similar goals for an interview — they each want to gather information. In a physician-patient conversation, asking fewer questions might mean affording the patient the uninterrupted opportunity to share information, opinions, and concerns about his or her medical condition.

Determine what details you want to take away from the interview and structure your conversation with the patient to help you obtain them. If the patient begins talking randomly, listen carefully to discern any important facts, then try to focus the patient’s conversation with your questions. “The more you use your mind to evaluate, compare, and contrast the source’s comments, the more you’ll ask those kinds of creative questions.”²

Journalists take notes or record their interviews. Physicians must also write notes for the medical record. Short-term memory of what took place at the interview deteriorates rapidly, so it is helpful to write notes during the interview. “Reporters often do not pay attention to comments made early in an interview”² because the comments are not in context. Later in the interview, when the reporter understands more, the comments become meaningful. If they have not been written down, however, they may not be remembered. The same holds true for the physician interviewing a patient.

Before conducting an interview with a source, journalists do their homework. Because they go into the interview knowing some things about their source, they are able to develop questions that will help them to better understand what their source has to say and any biases he or she may have. When a physician sits down with a patient, that physician will have the advantage of some previously supplied information. The patient may have completed a patient information form before the visit that provides the physician with information about his or her medical history and current complaint or the physician may review the patient’s information before sitting down with the patient. This can present a challenge. However, familiarity with this background

Active listening

Listening to and understanding a prepared speech is a very different experience from listening to and understanding information delivered in an interview. Prepared speeches follow a pattern with a theme and organized points. A

conversation is a different type of communication and may be hard to follow. One must listen carefully for major points and endeavor to grasp the meaning of what the source or patient is saying. We speak at about 125 words a minute, and we listen at 375-500 words a minute. Use the lag time to think ahead and anticipate where the patient may be headed in the conversation. Think about what was said and listen “between the lines.” For example, when your patient is answering a question is he or she blushing? Is the patient more that is not being said? What word choices are made? Word choice can reveal a lot about attitude and expectation. This kind of active listening can encourage exploration of an issue that may have been touched on but not directly stated.²

Many successful journalists are masters of active listening. Active listening is “. . . paying attention to the respondent’s message. It means asking questions that will ensure that you understand the message. It means mentally juggling the many aspects of the interview in short-term memory.”² It means being hearing during the conversation. And it means coming away with a record of what has been revealed. . . .²

In the patient interview, active listening promotes better communication and helps establish a trusting relationship between physician and patient. “Studies have shown that when this relationship is based on mutual trust and good communication, the chance of a malpractice claim being

Eye contact, note taking, and head nodding all tell the patient that you are actively listening. Although the typical may be a small part of that time, glancing at your watch while the patient is talking does not help the patient build the interviewer’s level of interest. Choose to make eye contact with the patient. If you are recording the patient interview in an electronic medical record, you will need to turn your attention to the computer screen from time to time. It is helpful to tell the patient what you are doing so they understand you are still focused on them and the reasons

To elucidate, repeat back what the patient is saying during the interview. Use phrases such as “As I understand it, you mean . . .” or “You are saying . . .” Journalists use this technique to make sure they are grasping the point their source is trying to make. Listen for contradictory statements to clarify with the patient. Listen for supporting evidence to statements the patient is making. Actively evaluating what is being said can prompt you to ask more questions while

For sources who have agreed to an interview with the journalist, the kinds of interviews that leave them with a negative impression are those where the interviewer asks a question, then settles back to record the answer without any kind of interaction with the source. Physicians can avoid this type of interview by offering encouragement and direction to the patient during the interview. Active listen

probe with additional questions.

A journalist might engage in self-disclosure statements during the interview in an effort to appear friendly and to help their source feel comfortable in being candid. However, a recent study published in the June 25, 2007 issue of the Archives of Internal Medicine suggests that physicians who engage in personal disclosure during the patient visit wasted the patient's time and did not enhance the doctor-patient relationship.⁵ In another study exploring the relationship between physician self-disclosure and patient satisfaction, physicians who disclosed during the visit when doctors self-disclosed while surgical patients were present were more likely to be sued.⁶ With this intriguing information in mind, the patient-physician interview could be more productive if the topics of discussion were prioritized to make the best use of the time available.

Journalists' interview tips

- Prepare for the interview
- Listen actively for major points, supporting evidence, counterpoints
- Listen "between the lines"
- Ask probing questions
- Evaluate what is being said
- Repeat for understanding
- Document the interview

Reduce your risk

Patients who have communication issues with their physician may be more likely to change doctors or to sue.

Consider changing doctors: physicians not giving understandable answers to questions; not taking enough time to answer questions; and not giving enough medical information.³

In a study comparing primary care physicians who have been sued with those who have not, communication played a key role. Physicians who prepare their patients about what to expect at the medical visit, encourage them to talk about their concerns and opinions, and who repeat information back to the patient are less likely to be sued.³ These physician behaviors establish mutual respect and trust.

Another study compared the communication styles of primary care physicians who had reported malpractice claims with physicians who had never reported malpractice claims. The study demonstrated that "... no-claims primary care physicians used more statements of orientation (e.g., "I'm glad to see you"), laughed and used humor more, and tended to use more facilitation (soliciting patients' opinions, checking understanding, and encouraging patient to talk). No-claims primary care physicians spent longer in routine visits than physicians with malpractice claims (17.5 minutes vs. 16.5 minutes), and the length of the visit had an independent effect in predicting claims status."

In an article titled, "Reducing risk of malpractice suits by forging patient relationships" the author offers several tips. One of these is to "take a course on physician-patient communication." The author says "even if you think you are an unbiased observer... how well you listen and communicate is an area you can control and improve."³

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Important announcement for policyholders — Bob Fields named president and CEO

The TMLT Governing Board has announced their selection of Bob Fields as the new president and CEO since August 2006. Prior to that, he was executive vice president of claim operations at TMLT.

“I am honored to serve our policyholders in this capacity. TMLT is an organization with a long history of leading the medical liability industry in our state. I plan to continue this legacy of providing innovative products, strong defense, and advocacy,” says Fields.

Mr. Fields has more than 34 years experience in the insurance industry. After working for The Hartford for nearly 13 years, he came to TMLT as a territorial supervisor promoted to executive vice president in 1994. He has an enviable track record in the area of medical malpractice claim management. He is a past member of the Physician Insurers Association of America claim section committee and has served as chairman of the state’s Joint Underwriting Association claim review committee.

Mr. Fields has also represented the interests of TMLT policyholders concerning legislative affairs. He is a past member of the Texas Medical Association/Texas Trial Lawyers Association medical malpractice legislative negotiating team, a current member of the Texas Alliance for Patient Access legislative committee, and was a frequent public speaker concerning the need for medical liability reform before the passage of House Bill 4 and Proposition 12.

Mr. Fields received a bachelor’s degree in business education from Southeast Missouri State University and a master’s degree in business administration, with honors, as Captain.

“With more than 30 competing carriers currently in Texas, we have some challenges staff can meet those challenges successfully,” says Fields.



Pediatric cancer survivors: identifying and treating late effects

Course author

Louise Walling is a risk management representative at TMLT.

Disclosure

There are no financial relationships or 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 credit.

Estimated time to complete activity

It should take approximately 1 hour to read this article and complete the questions.

Release/review date

This activity is released on August 1, 2007 and expires on August 1, 2009. Please note this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Introduction

It has been said that "Children don't get cancer; families do." The initial shock, uncertainty, disruption, and concern about mounting medical expenses affect each family member. Handling new demands while maintaining the routine activities of daily living places strain on each member

Objectives

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

1. list three late effects commonly associated with childhood cancer treatment;
2. identify the primary assessment tool for identifying late effects; and
3. list the source for updated guidelines for the follow-up treatment of late effects.

of the family.

The caregiver waits for the results of each test and hangs on every word of the pediatric oncologist. Relief comes when the D Q Q R X Q F H P H Q W R I D U H P However, this relief may be short lived as new and unexpected physical, cognitive, and psychosocial health issues surface that require long-term follow-up care from a team of health care professionals.

“The end of cancer is not the end of the cancer experience”.¹ Long-term effects from chemotherapy, radiotherapy, and surgery K D Y H E H H Q L G H Q W L Å H G - 3 X E A O N E M K H D E A Y E H E F R E S P O O R within weeks or months of cancer treatment, and late effects occur months or years after treatment. The medical community distinguishes between effects and complications E \ G H Å Q L Q J H I I H F W V D V H [S e c o n d a r y a p p a r e n t o v e r t i m e P S O L The parent of a cancer survivor offered this story in the book *Childhood Cancer Survivors: A Practical Guide to Your Future* My G D X J K W H U K D G F * < R I U D C K S D O V S B Q e a r s o l d R U I n g p r e s e n t h o and kindergarten, she had the most beautiful handwriting. She was also a great artist and could draw using perspective at an early age. By the time she was 7, however, her handwriting started to deteriorate and she had trouble writing in a straight line — her s e r i e s e s t e n d i n g t o s l o p e K u p . She reverted W R G U D Z L Q J V W L F N Å J X U H V 6 i n g r e a l l y h a r d o n t h e p a p e r w h e n d r a w i n g o r w r i t i n g , a n d t h e p r o c e s s b e c a m e v e r y a b o r i o u s . U S E P n o w m o s t l y u s e s a w o r d p r o c e s s o r f o r w r i t i n g p r o j e c t s , a n d w e a r e n e g o t i a t i n g w i t h t h e s c h o o l f o r h e r t o u s e a l a p t o p (t h e y w a l k u s e s t i v e t e c h n o l o g y) i n s c h o o l . S h e h a s p r o b l e m s w i t h m a t h a n d K D V V R F L D O G L I Å F X O W L E H V E H a l l y f o l l o w c o n v e r s a t i o n s w e l l . H e r n e u r o - p s y c h o l o g i c a l s c o r e s r a n g e f r o m t h e 5 t h t o t h e 9 5 t h p e r c e n t i l e . ” ¹⁰

Statistics of survival

6 L J Q L Å F D Q W D G Y D Q F H P H O Y W O a d u l t s w h o w e r e d i a g n o s e d w i t h F D Q F H U E H W Z H H Q - e s t r i s k f o r l a t e e f f e c t s w e r e s u r v i v o r s o f b o n e t u m o r s , C N S t u m o r s , a n d H o d g k i n ' s d i s e a s e . T h e m e a n a g e o f t h e s u r v i v o r s w a s 3 6 . 5 y e a r s . M o r e t h a n 5 5 % o f t h e s u r v i v o r s r e p o r t e d a t l e a s t o n e c h r o n i c c o n d i t i o n w i t h U H S R U W L Q J D V H Y H U H c o n d i t i o n . ⁶

The majority of cancers diagnosed in the early years of life are leukemias, central nervous system (CNS) cancers, and lymphomas. The most common form of leukemia K D V D O P R V W D Q Å Y H \ H V Å J 7 3 . 4 % w i t h a d u b l e t h e i n c i d e n c e o f 4 2 . 4 % f o r a s e v e r e , d i s a b l i n g , o r l i f e - t h r e a t e n i n g c o n d i t i o n o r d e a t h r e s u l t i n g f r o m a c h r o n i c c o n d i t i o n . ” ³

\$ U H F H Q W Å Q G L Q J L O O - X T e x t o f l a t e e f f e c t s w i t h D O V X U R O G L O u g h t t h e l e d i c a l s c h o o l d i s t r i c t c a n h e l p t h e p a t i e n t o b t a i n s e r v i c e s t h a t h e o r s h e i s d e l a y i n g i n a t t e n d i n g t o . W e h e / H

Currently 1 in 640 individuals between the ages of 20 and 39 is a childhood cancer survivor. Due to the advancements in pediatric oncology and research, long-term survivors are increasing in number. In the near future that number will grow to 1 of every 450 individuals. ³

Children undergoing treatment for cancer participate in clinical trials much more frequently than adults, resulting in considerable progress for improved prognosis of childhood cancers. Recently, patients have E H Q H Å W H G I U R P R Q J R L Q J Y N e u r o c o g n i t i v e i m p a i r m e n t s a r e m o s t

ment, new combinations of agents, different doses of drugs or radiation, entirely new approaches or alternate modes of administration. With reliable data about late L H V H L R W V L D Q Y G H B E A S H Å F D W L R Q Y m p o m a s k t h a t d i s o l v e s i n t a b e c a l F K H P R W K H U D S \ D Q G R U V S H F therapy. An estimated 60% of all pediatric oncology patients are at risk for neurocognitive impairments as 40% of childhood malignancies are leukemias and lymphomas and 20% are CNS tumors.

Prevalence of late effects

7 K R X J K W K H G H Å Q L W L R Q R a l i g a n c i e s a r e l e u k e m i a s a n d l y m p h o m a s a n d 2 0 % a r e C N S t u m o r s . These impairments are most frequently manifested as learning disabilities, social G L I Å F X O W L H V E H K D Y L R U D O D l e m s , a n d l o n g - t e r m e d u c a t i o n a n d v o c a - W L R Q D O K D Q G L F D S V ' H Å F L W m e m o r y , p r o c e s s i n g s p e e d , v i s u a l m o t o r i n t e g r a t i o n , a t t e n t i o n , a n d c o n c e n t r a t i o n m a y b e c o m e a p p a r e n t o v e r t i m e P S O L The parent of a cancer survivor offered this story in the book *Childhood Cancer Survivors: A Practical Guide to Your Future* My G D X J K W H U K D G F * < R I U D C K S D O V S B Q e a r s o l d R U I n g p r e s e n t h o and kindergarten, she had the most beautiful handwriting. She was also a great artist and could draw using perspective at an early age. By the time she was 7, however, her handwriting started to deteriorate and she had trouble writing in a straight line — her s e r i e s e s t e n d i n g t o s l o p e K u p . She reverted W R G U D Z L Q J V W L F N Å J X U H V 6 i n g r e a l l y h a r d o n t h e p a p e r w h e n d r a w i n g o r w r i t i n g , a n d t h e p r o c e s s b e c a m e v e r y a b o r i o u s . U S E P n o w m o s t l y u s e s a w o r d p r o c e s s o r f o r w r i t i n g p r o j e c t s , a n d w e a r e n e g o t i a t i n g w i t h t h e s c h o o l f o r h e r t o u s e a l a p t o p (t h e y w a l k u s e s t i v e t e c h n o l o g y) i n s c h o o l . S h e h a s p r o b l e m s w i t h m a t h a n d K D V V R F L D O G L I Å F X O W L E H V E H a l l y f o l l o w c o n v e r s a t i o n s w e l l . H e r n e u r o - p s y c h o l o g i c a l s c o r e s r a n g e f r o m t h e 5 t h t o t h e 9 5 t h p e r c e n t i l e . ” ¹⁰

An estimated 270,000 survivors of childhood cancer live in the U.S.⁵ For those patients treated with aggressive protocols in W K H V V L J Q L Å F D Q W - F K S D O V S B Q e a r s o l d R U I n g p r e s e n t h o and kindergarten, she had the most beautiful handwriting. She was also a great artist and could draw using perspective at an early age. By the time she was 7, however, her handwriting started to deteriorate and she had trouble writing in a straight line — her s e r i e s e s t e n d i n g t o s l o p e K u p . She reverted W R G U D Z L Q J V W L F N Å J X U H V 6 i n g r e a l l y h a r d o n t h e p a p e r w h e n d r a w i n g o r w r i t i n g , a n d t h e p r o c e s s b e c a m e v e r y a b o r i o u s . U S E P n o w m o s t l y u s e s a w o r d p r o c e s s o r f o r w r i t i n g p r o j e c t s , a n d w e a r e n e g o t i a t i n g w i t h t h e s c h o o l f o r h e r t o u s e a l a p t o p (t h e y w a l k u s e s t i v e t e c h n o l o g y) i n s c h o o l . S h e h a s p r o b l e m s w i t h m a t h a n d K D V V R F L D O G L I Å F X O W L E H V E H a l l y f o l l o w c o n v e r s a t i o n s w e l l . H e r n e u r o - p s y c h o l o g i c a l s c o r e s r a n g e f r o m t h e 5 t h t o t h e 9 5 t h p e r c e n t i l e . ” ¹⁰

The 2006 Childhood Cancer Survivor Study (CCSS), published in the *Journal of the American Medical Association* involved 27 institutions that gathered data on nearly 40,000 adults who were diagnosed with F D Q F H U E H W Z H H Q - e s t r i s k f o r l a t e e f f e c t s w e r e s u r v i v o r s o f b o n e t u m o r s , C N S t u m o r s , a n d H o d g k i n ' s d i s e a s e . T h e m e a n a g e o f t h e s u r v i v o r s w a s 3 6 . 5 y e a r s . M o r e t h a n 5 5 % o f t h e s u r v i v o r s r e p o r t e d a t l e a s t o n e c h r o n i c c o n d i t i o n w i t h U H S R U W L Q J D V H Y H U H c o n d i t i o n . ⁶

“The cumulative incidence of a chronic health condition 30 years after diagnosis H V Å J 7 3 . 4 % w i t h a d u b l e t h e i n c i d e n c e o f 4 2 . 4 % f o r a s e v e r e , d i s a b l i n g , o r l i f e - t h r e a t e n i n g c o n d i t i o n o r d e a t h r e s u l t i n g f r o m a c h r o n i c c o n d i t i o n . ” ³

\$ U H F H Q W Å Q G L Q J L O O - X T e x t o f l a t e e f f e c t s w i t h D O V X U R O G L O u g h t t h e l e d i c a l s c h o o l d i s t r i c t c a n h e l p t h e p a t i e n t o b t a i n s e r v i c e s t h a t h e o r s h e i s d e l a y i n g i n a t t e n d i n g t o . W e h e / H

Neurocognitive dysfunction

\$ Q X P E H U R I Y D U L D E O H V S t e s a s a c a d e m i c u n d e r a c h i e v e m e n t , u n e m p l o y m e n t , a n d / o r p o s t - t r a u m a t i c s t r e s s d i s o r d e r m a y a p p e a r i n 1 0 % t o 2 0 % o f l o n g - t e r m s u r v i v o r s o f c h i l d h o o d c a n c e r . ³

Q A A t t u d o a t t h e D a n e F o r e C a n c e r I n s t i t u t e a s s e s s e d 1 0 1 a d u l t c a n c e r s u r v i v o r s w i t h a p s y c h o l o g i c a l s c r e e n i n g p e r f o r m e d

commonly seen among children whose cancer or treatment involved the central nervous system. Included in this group are those treated for brain tumors, leukemias and lymphomas. An estimated 60% of all pediatric oncology patients are at risk for neurocognitive impairments as 40% of childhood malignancies are leukemias and lymphomas and 20% are CNS tumors.

These impairments are most frequently manifested as learning disabilities, social G L I Å F X O W L H V E H K D Y L R U D O D l e m s , a n d l o n g - t e r m e d u c a t i o n a n d v o c a - W L R Q D O K D Q G L F D S V ' H Å F L W m e m o r y , p r o c e s s i n g s p e e d , v i s u a l m o t o r i n t e g r a t i o n , a t t e n t i o n , a n d c o n c e n t r a t i o n m a y b e c o m e a p p a r e n t o v e r t i m e P S O L

The parent of a cancer survivor offered this story in the book *Childhood Cancer Survivors: A Practical Guide to Your Future* My G D X J K W H U K D G F * < R I U D C K S D O V S B Q e a r s o l d R U I n g p r e s e n t h o and kindergarten, she had the most beautiful handwriting. She was also a great artist and could draw using perspective at an early age. By the time she was 7, however, her handwriting started to deteriorate and she had trouble writing in a straight line — her s e r i e s e s t e n d i n g t o s l o p e K u p . She reverted W R G U D Z L Q J V W L F N Å J X U H V 6 i n g r e a l l y h a r d o n t h e p a p e r w h e n d r a w i n g o r w r i t i n g , a n d t h e p r o c e s s b e c a m e v e r y a b o r i o u s . U S E P n o w m o s t l y u s e s a w o r d p r o c e s s o r f o r w r i t i n g p r o j e c t s , a n d w e a r e n e g o t i a t i n g w i t h t h e s c h o o l f o r h e r t o u s e a l a p t o p (t h e y w a l k u s e s t i v e t e c h n o l o g y) i n s c h o o l . S h e h a s p r o b l e m s w i t h m a t h a n d K D V V R F L D O G L I Å F X O W L E H V E H a l l y f o l l o w c o n v e r s a t i o n s w e l l . H e r n e u r o - p s y c h o l o g i c a l s c o r e s r a n g e f r o m t h e 5 t h t o t h e 9 5 t h p e r c e n t i l e . ” ¹⁰

Identifying the symptoms, initiating referrals for neurocognitive testing, or involving the availability of resources through the local school district can help the patient obtain services that he or she is delaying in attending to. We he / H

Psychosocial outcomes

Included among the late effects are adverse psychological outcomes. Maladjustment, mood disturbances, behavioral mood disturbances, behavioral problems, somatic distress, academic underachievement, unemployment, and/or post-traumatic stress disorder may appear in 10% to 20% of long-term survivors of childhood cancer. ³

Q A A t t u d o a t t h e D a n e F o r e C a n c e r I n s t i t u t e a s s e s s e d 1 0 1 a d u l t c a n c e r s u r v i v o r s w i t h a p s y c h o l o g i c a l s c r e e n i n g p e r f o r m e d

Selected physical late effects associated with childhood cancer

Cancer	Potential late effects	
Leukemias	<ul style="list-style-type: none"> • cognitive effects (e.g., learning disabilities) • abnormal growth and maturation • heart problems • avascular necrosis of the bone • Hepatitis C (effect of blood transfusion) 	<ul style="list-style-type: none"> • weakness, fatigue • osteoporosis • second cancers • dental problems
Brain cancer	<ul style="list-style-type: none"> • cognitive effects (e.g., learning disabilities) • abnormal growth and maturation • hearing loss • kidney damage 	<ul style="list-style-type: none"> • Hepatitis C • infertility • vision problems • second cancers
Hodgkin 's disease	<ul style="list-style-type: none"> • adhesions and intestinal obstruction (if spleen removed) • decreased resistance to infection (potential for life-threatening sepsis) • abnormal growth and maturation • salivary gland malfunction 	<ul style="list-style-type: none"> • lung damage • heart problems • infertility • Hepatitis C • second cancers (breast)
Non-Hodgkin 's lymphoma	<ul style="list-style-type: none"> • heart problems • Hepatitis C • osteopenia/osteoporosis 	<ul style="list-style-type: none"> • infertility • cognitive effects
% R Q H W X P R U	<ul style="list-style-type: none"> ‡ DPSXWDWLRQ GLVÀJXUHPHQW ‡ KHDULQJ ORVV • functional, activity limitations • damage to soft tissues and underlying bones (scarring, swelling, or inhibited growth) • heart problems 	<ul style="list-style-type: none"> • kidney damage • Hepatitis C • fertility problems
Wilm 's tumor	<ul style="list-style-type: none"> • heart problems • kidney damage • damage to soft tissues and underlying bones (scarring, swelling, or inhibited growth) 	<ul style="list-style-type: none"> • second cancers • fertility problems • scoliosis
Neuroblastoma	<ul style="list-style-type: none"> • heart problems • damage to soft tissues and underlying bones (scarring, swelling, or inhibited growth) • neurocognitive effects 	<ul style="list-style-type: none"> • hearing loss • Hepatitis C • second cancers • kidney damage
6 RIW WL V V X H V D U F R P ‡	<ul style="list-style-type: none"> ‡ DPSXWDWLRQ GLVÀJXUHPHQW ‡ V H F R Q G F D Q F H U V • functional, activity limitations • heart problems • damage to soft tissues and underlying bones (scarring, swelling, or inhibited growth) 	<ul style="list-style-type: none"> • Hepatitis C • kidney damage • infertility • neurocognitive effects

Source: Institute of Medicine. Childhood cancer survivorship: Improving care and quality of life. August 2003.

during a routine annual evaluation. The testing revealed 32 subjects had a positive screen for psychological distress and 14 subjects reported at least one suicidal symptom. Risk factors for psychological distress included the subjects' dissatisfaction with physical appearance, poor physical health, and treatment with cranial radiation.

Primary care physicians or those pediatricians, internists, family physicians, and obstetricians/gynecologists treating cancer survivors can monitor this risk with a comprehensive history and physical and an annual psychological screening test.³

Late-onset cardiac conditions

In the last 10 years, research has shown that childhood cancer patients treated with an anthracycline, notably daunorubicin and doxorubicin, are at risk for developing late onset cardiomyopathy characterized by the development of a dilated thin-walled left ventricle. Female sex, younger age at treatment, higher rate of administration of doxorubicin, cumulative dose of doxorubicin, and concurrent chest/mantle radiation are independent risk factors for the altered left ventricular function.⁹ Pregnant women with a history of anthracycline therapy are faced with an increased risk of cardiomyopathy due to the 40% increase in blood volume that occurs during pregnancy.³

One cancer survivor relates her story: "According to doctors, my heart failure was most likely caused by adding stress to a heart that was already weak from chemotherapy treatments. Although I remember being told that some of my treatments could cause heart damage, kidney failure, or bladder damage, I don't recall being told to monitor heart status after being released from treatment and especially during pregnancy. I am being compensated with medicines now, however, my doctors feel that I will probably need a heart transplant in the next two years."⁹

Other cardiac conditions including valvular disease, pericardial disease, and arrhythmias have been reported. Increased risk factors for long-term cardiac damage include: female sex; patients treated under the age of 4; patients treated with other drugs that affect the heart; and patients who underwent thoracic radiation.

Periodic monitoring of left ventricular function of asymptomatic cancer survivors who were treated with moderate to high doses of anthracyclines is recommended.⁹ If the patient is pregnant, obstetricians are advised to order an echocardiogram every trimester with at least one evaluation by a cardiologist. Otherwise, monitoring should

include an annual history and physical examination and echocardiogram every year for two years and then every two years if the results of the exam are normal.³

Thyroid conditions

Hyperthyroidism or hypothyroidism may occur after radiation to the thoracic spine, cranium, or neck. In a study of 1677 children and adults with Hodgkin's lymphoma who were treated with radiation experienced overt or sub-clinical hypothyroidism with a peak incidence at two to three years post-treatment.

A Childhood Cancer Survivor Study of 13,674 patients with Hodgkin's lymphoma showed the greatest risk to those patients who had increased doses of radiation, were treated at an older age (older than 15 years), and were female. Hypothyroidism was 25% of the respondents. In the same study, the rate of recurrence for hyperthyroidism occurred in 5% of the patients.³

Another source notes that the majority of Hodgkin's survivors who received mantle radiation and up to 50% of bone marrow transplant patients develop hypothyroidism. Treatment at a young age may also increase the likelihood of developing a thyroid problem.

An elevated thyroid-stimulating hormone (TSH) level and a normal or depressed thyroxine (T4) level in an asymptomatic patient may indicate compensated hypothyroidism. Even with the etiology unclear, most endocrinologists support treatment.

A cancer survivor relates her story: "My Hodgkin's disease was treated with chemotherapy with areas of involvement getting the highest boost. Naturally, we were warned at the start that I could have thyroid dysfunction from treatment. My hematologist monitored this periodically after treatment via the standard T4/T3/TSH blood work, and my TSH was a little high, but my T4 was normal, and explained that I would need to start thyroxine if my T4 came back low the next time. It didn't, but my TSH was still high, so we just kept monitoring annually since I wasn't really having any symptoms. I have had off-and-on episodes of weight gain that my major weight gain occurred just before those tests went awry. When I began to see a new doctor, he discussed the situation with me and said that he felt I should

start thyroxine replacement even if my T4 remained normal, since there is some evidence that prolonged elevation of TSH may increase the risk of thyroid cancer. I've been on 0.1 mg of Synthroid® once daily since March 1997. We monitor my blood work twice a year, and he thinks I may have to go up on dosage — most people, he says, eventually do need more. His feeling was that I'd probably feel a lot better on it, and I do have more energy now."¹⁰

Uncompensated hypothyroidism includes both an elevated TSH level and a depressed T4. Thyroid hormone replacement the primary care physician include annual monitoring with tests for thyrotropin and free-thyroxine levels.³

Obesity

Childhood cancer survivors treated with cranial radiation therapy is thought to decrease the growth hormone. In addition, steroid therapy, physical inactivity with reduced exercise capacity, and increased dietary intake augment the risk.

It is currently accepted that obesity in childhood, adolescence, and young adulthood is an important predictor of the eventual development of adult-onset diabetes mellitus, hypertension, dyslipidemia, and cardiovascular disease. Periodic follow-up to assess weight, activity level, and screen for potential obesity-related disease is important for adult cancer survivors, especially those treated with cranial radiation.⁹

Skeletal problems

Many survivors of childhood cancer are also at risk for osteoporosis. The chemotherapeutic agents of corticosteroids and methotrexate appear to alter bone metabolism resulting in a reduction of peak bone mass. Several studies with median ages at evaluation from 12 to 25 years consistently show reduction in bone mineral density and/or age-adjusted bone mass.⁹ Cranial radiation can cause pituitary dysfunction making growth hormone secretion inadequate, causing abnormal bone metabolism. Osteopenia, avascular necrosis, spinal deformities and other skeletal changes can also occur.³

Not only cancer survivors should be periodically assessed to determine the risk for osteoporosis, counseled regarding adequate calcium intake, encouraged to routinely exercise, and advised to avoid smok-

ing.⁹ Monitoring should include an annual scoliosis screen and a bone density study two or three years after therapy. If the results are normal, screening does not have to be repeated unless clinical signs and symptoms appear.³

Secondary neoplasms

Childhood cancer survivors are at a greater than 19-fold increased risk for developing another malignancy.³

Women treated with mantle radiation for childhood Hodgkin's disease had a significant increase in risk for the development of breast cancer, with a cumulative incidence of about 35% at 20 to 25 years post-therapy.⁸ With nearly 120,000 survivors of Hodgkin's lymphoma in the United States, secondary malignant neoplasms are the leading cause of death for long-term survivors. Breast cancer is the most frequent solid tumor diagnosed in women survivors. The incidence of breast cancer, highest for women treated at 10 to 20 years of age, increases as patients age after therapy. The risk of recurrence correlates to the dose of radiation administered. Most secondary breast cancers

A survivor of non-Hodgkin's lymphoma breast cancer stated: "I had stage IV non-Hodgkin's lymphoma when I was 16. The tumor had metastasized to the bone by the time I was diagnosed. I had lots of radiation and chemotherapy, I also had numerous chest x-rays during the 2 years of treatment. Nine years later I was diagnosed with breast cancer. Luckily, it had not spread to my lymph nodes. I had surgery, but no chemo or radiation and am doing

Whether there is an increased risk of breast tumors in males who receive thoracic radiation has not yet been determined.

Early diagnosis of breast cancer can be achieved by encouraging patients to perform monthly breast self-exams and obtaining a yearly mammogram. The Children's Oncology Group, an international clinical trial cooperative group supported by the National Cancer Institute, recommends a mammogram eight years after therapy or at age 25, whichever is later.³

Follow-up care

With the increased survival rates of childhood cancer survivors, the need for potential late effects has been acknowledged. This has led to the development of treatments that focus not only on cancer-free survival, but also quality of life and long-term health. In the 1990s, cancer centers developed programs for patients and

their families that primarily dealt with follow up for acute problems and recurrence of age. The option for longitudinal care was not yet developed.

For cancer patients, the jubilation of getting off treatment is followed by an unavoidable period of sorting through continued fears and concerns about the unknown and dealing with the consequence of treatment. Rather than interpreting the history of one's cancer as a single event, it should be viewed as a process that extends throughout the survivor's lifetime. This health behaviors of the patient.⁹

Fitzhugh Mullan, MD, co-founder of the National Coalition for Cancer Survivorship said, "It is as if we have invented sophisticated techniques to save people from drowning, but once they have been pulled from the water, we leave them on the dock to cough and sputter on their own in the belief we have done all we can."¹⁰

In 1996 the International Society of Pediatric Oncologists developed guidelines for the care of childhood cancer survivors. The International Society of Pediatric Oncologists advocated the establishment of a specialty clinic not only to maintain the absence of disease, but to offer preventive medical and psychosocial care with the goal of promoting long-term physical, psychosocial, and social-economic health and productivity. The American Society of Pediatric Hematologist/Oncologists published standards for comprehensive long-term follow-up programs that same year. In 1997, the American Academy of Pediatrics stressed the importance of long-term follow-up care with a specialist acquainted with the adverse effects of treatment.¹⁰

"Three primary models exist to assist the patient in transition or offer programs for adult survivors of pediatric cancer:

- continued follow-up of adult survivors at the childhood cancer center;
- one-time evaluation of adult survivors at a childhood cancer center with a summary provided to the survivor and their primary care physician; and
- multi-disciplinary collaborative efforts between pediatric oncologist and health care provider experienced with adult health problems."⁹

Barriers to follow-up

Unfortunately, statistics on follow-up care for most adult survivors are not encouraging. While monitoring for late effects is important to their overall health, one study found that less than 20% of adult survivors are followed by an oncologist or

at a cancer center. A National Institutes of Health study showed that 50% of 14,000 long-term cancer survivors had not been seen by a doctor during the previous two years for evaluation of cancer-related problems.⁹

Several barriers exist that prevent access to care. Survivors may have a tendency to engage in avoidance strategies to distance themselves from the experience of the disease and risks of late effects to create a sense of normalcy. A lack of knowledge of the illness, treatment protocols, and relevant risks for late effects are often not a part of the survivor's experience.

One cancer survivor stated: "I am a survivor of Hodgkin's Disease diagnosed in 1971 at age 16. My mother died of HD when I was 4. I was treated with high dose radiation only. I do not know my stage or level of rads. I have no documentation from (treating institution). I asked for it a couple of years ago and they said it was in storage somewhere."⁹

Pediatric oncologists who are not involved in regular follow-up of childhood cancer survivors face the challenge of dealing with a moving target as this area of research is continually changing.

A survivor described his experience seeking long-term follow-up care: "Many patients attempt getting long-term care via oncologists. Yet it seems that oncologists have enough to do to keep up with current acute care issues, and are not interested in long-term care — in particular where it in - YROYHV WKH SV\FKRORJLFDONITION that long-term effects are often treatment effects, and that the science of what to do is murky."⁹

Other health care professionals may view the survivor's history of cancer as having no affect on the patient's current health status. Other physicians may feel that a relationship exists between the survivor's current health status and his or her childhood cancer and treatment, but time FRQVWUDLQWV PD\ QHJDWLYH pursuit of optimal follow-up care.

As the number of Americans without health insurance rises each day, the issue of affordable health care is often a major challenge for the adult cancer survivor. Cognitive effects such as memory and processing problems often make the survivor less competitive in the marketplace for a MRE ZLWK KHDOWK EHQHAWV such as laboratory tests, mammography, echocardiography, and bone densitometry are expensive, especially when all fees must be paid out of pocket. Even those patients who have health insurance are often faced

with denials from the insurance company uninformed about the screening needs for this at-risk population. ⁹

Guidelines

In 2004 the Children’s Oncology Group published follow-up guidelines to help cancer survivors and health care providers. ⁷ 7 KH JXLGHOLQH V LGHQWLAHG 1935 North Street, Dallas, TX 75235-7794 screening and management of late effects and represented a consensus from a panel of experts and a multidisciplinary review panel. The goal of this effort was to create a standard for follow-up care throughout a cancer survivor’s lifespan. The target audience is medical professionals providing frontline health care to survivors of pediatric cancer. Since the guidelines are updated annually, physicians are advised to review the web site at www.survivorshipguidelines.org for the latest revision. ⁷

The guidelines are intended for use beginning two or more years after the completion of cancer therapy, and provide a framework for monitoring late effects only. They are not designed to follow the patient’s primary disease. In order to facilitate quick access, the guidelines are organized according to the survivor’s age at diagnosis, type of cancer, and history of treatment (chemotherapy, radiation, surgery or other therapeutic methods). The guidelines also allow the physician to take into account other risk factors, health-related behaviors, and comorbidities. ¹¹

Most importantly, the physician must have a summary of cancer treatment. If the patient does not have the medical records, a summary of treatment from the facility can be requested. Only with this information can the physician make informed decisions and accurate follow-up recommendations.

The periodic screening recommendations emphasize the use of a thorough history and physical examination as the primary assessment for late effects. Accordingly, 101 (74%) screening recommendations outlined for 136 therapeutic exposures are derived primarily from the history and physical; 33 (24%) rely on the history and physical plus a baseline diagnostic study (e.g., lab, imaging); 31 (23%) include periodic laboratory, diagnostic imaging, or other testing; and 4 (3%) recommend no screening (agents with no known late effects). ¹¹

Resources

It is also important for primary care physicians to be informed about the appropri-

The following clinics in Texas offer comprehensive services to teens and adults who are survivors of childhood cancer.

After the Cancer Experience (ACE)
Children’s Medical Center of Dallas
 1935 North Street, Dallas, TX 75235-7794

http://www.childrens.com/Patients_Families/HospitalServices.cfm?servicesID=69
 Monitors children, adolescents and young adult survivors of childhood cancer.

Life After Cancer Care Clinic
MD Anderson Cancer Center
 1515 Holcombe, Houston, TX 77030

<http://www.mdanderson.org/departments/lacc/>
 The program is for people who have been treated for cancer in the past, are now considered disease-free, and no longer see their oncologist on a regular basis.

Long Term Survivor Program
Texas Children’s Cancer Center and Hematology Service
 6621 Fannin St., CC 1410.00, Houston, Texas 77030-2399

http://www.txccc.org/content.cfm?content_id=1201#Contact
 The program sees patients of any cancer diagnosis two years after the completion of therapy.

Life After Cancer Program
Cook Children’s Medical Center
 Hematology & Oncology Center
 666 North Dearborn Street, Chicago, IL 60611

<http://www.cookchildrens.org>
 Provides medical care for childhood and adolescent cancer survivors up to age 30 who are two years after the completion of therapy.

The LIVESTRONG Survivorship Center
Dell Children’s Medical Center of Central Texas
 707 West 19th Street, Austin, TX 78701

http://www.dellchildrens.net/services_and_programs/childhood_cancer_blood_disorders_center/livestrong_survivorship_center/
 Provides services to patients who are two years after the completion of therapy or 10 years after diagnosis or upon graduation from school, whichever occurs last.

Childhood Cancer Survivors Clinic
CHRISTUS Santa Rosa Children’s Hospital
 Division of Pediatrics Hem/Onc/Imm
 1600 West 19th Street, Austin, TX 78701
 (210) 704-3405
<http://www.pediatrics.uthscsa.edu/Hematology-Oncology/survivors.asp>
 Offers services to patients two years after the completion of therapy and/or 10 years after diagnosis or upon graduation from school, whichever occurs last.

ate referral sources that offer specialized services for patients who are childhood cancer survivors.

The After the Cancer Experience (ACE) program at Children's Medical Center Dallas and UT Southwestern provides long-term monitoring for children, adolescents, and young adult survivors of childhood cancer. The program follows cancer patients who are disease-free and have been off therapy for at least two years. The ACE program is one of just a few long-term follow-up cancer survivor programs in the country. This program works closely with the patient's referring physician and monitors for late effects, screening for second malignancies, and provides referrals to appropriate specialists. According to a 2004 report, the ACE program currently has 1266 patients in its database and 440 of those patients were seen in 2004.¹²

The Texas Children's Cancer Center in Houston also offers long-term survivor services. A web site www.cancersurvivorchild.org provides information on the physical, psychosocial, and potential health issues that may be helpful to survivors, family or health care providers. The Texas Children's Cancer Center is also involved in studies focused on early diagnosis and intervention with late complications and is conducting research to design future therapies that reduce the risk of late effects.¹³

"Researchers at Texas Children's Cancer Center, Baylor College of Medicine's Center for Collaborative and Interactive Technologies, and the Children's Oncology Group are collaborating to produce an Internet resource for physicians and patients — the Passport for Care. The Passport for Care web site will include:

- an end-of-treatment care summary with recommendations that can be shared securely with health care professionals;
- customized recommendations for follow-up care based on treatment history;
- a system to provide survivors with updated changes in their surveillance guidelines; and
- customized education materials." ¹⁴

"Consistent medical follow-up for cancer survivors is complicated by several factors: Americans change primary health care providers every 2 years on average; survivors are not familiar with the details of their treatment history and cannot accurately share pertinent medical information with their health care providers; and primary care providers often are unfamiliar with cancer treatments or with the potential

long-term complications of cancer and cancer therapy."¹⁴

After the initial testing phase in the Long-Term Survivor Clinic at Texas Children's Cancer Center, a pilot version of Passport for Care will be launched at three additional survivor clinics around the country. ¹⁴

Conclusion

The medical profession can boast of great advances in the treatment and prognosis of pediatric malignancies over the past 30 years. Yet a professional and ethical responsibility is still owed to those living with life-altering effects as a result of the treatment. The primary care physician may E H W K H Å U V W W R R Es V a t e l e Y H c c u r e n t F a l l U 2 0 0 5 / A v a i l a b l e at <http://www.childrens.com/ccbd/>. Accessed on June 21, 2007.

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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. Rapid advancements have been made in pediatric oncology due to which of the following:
 - Most children do not understand the gravity of disease, their stress level is less which contributes to a better prognosis.
 - Most cancer research and funding have focused on treating childhood cancer.
 - Children participate in clinical trials more frequently than adults.
 - All of the above.

2. With the emergence of new treatment protocols in pediatric malignancies, risk of late effects from treatment no longer exists.
 - True
 - False

3. Gathering and reviewing a patient's health history is the primary care physician's first step to identify and treat late effects in childhood cancer survivors.
 - True
 - False

4. For a pediatric cancer survivor, cumulative incidence of chronic health conditions is:
 - 28%
 - 73.4%
 - 42%
 - 61%

5. Access to optimal health care for adult survivors of pediatric cancer includes:
 - Access to oncology health records
 - Overcoming barriers to treatment
 - Seeking care from an informed primary care physician
 - All of the above

6. Guidelines for treatment of late effects of pediatric cancer were originally published by the Children's Oncology Group in 1997.
 - True
 - False

Statement of completion

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

Physician signature _____ Date _____

CME evaluation form

Please complete the following regarding the article, "Pediatric cancer survivors."
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

claim studies

Failure to diagnose bacterial infection

by Barbara Rose and Laura Brockway

The following closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. These cases illustrate how a cleft knee, a complete blood count with differential, an erythrocyte sedimentation rate (ESR), and a c-reactive protein (CRP) test. The labs were not ordered on a stat basis. The x-rays were taken at an imaging center that evening. They were reported back to the pediatrician's office the morning of January 19. That same morning at 9 a.m., the mother called the pediatrician's office and said she was going for the lab work that morning. The patient did not sleep that night, and the pain had moved to her left arm. The nurse who had this conversation with the patient's mother noted "1. ? if peripheral neuritis; 2. ? pain med (Tylenol and Advil don't help); and 3. ? antibiotics." The nurse spoke with Pediatrician 3 about this phone call. Pediatrician 3 recommended waiting for the lab results before starting treatment. She explained that starting antibiotics would be ultimately necessary. Further, stronger pain medication could mask the symptoms, and the patient's labs were drawn at 11:30 a.m. on January 19. At 9:04 a.m. January 20, the lab issued a partial report that showed a white blood count of 16,000 (normal 5,000 to 16,000) with a left shift (50% neutrophils, 42% bands, 6% lymphocytes, and 2% monocytes). The CRP was not reported, but was issued in a supplement to the patient's records, both lab reports were on the printer at the pediatrician's office the morning of January 20 — after the labs were drawn but before they were reported to the pediatrician — the mother as "very ill, screaming in pain." She could not walk and the pain was now in her arms and legs. The mother again advised that the patient had no fever since January 17.

Presentation and physician action

The mother of a seven-year-old girl called her child's pediatrician on January 13 reporting that the child had a headache and fever up to 102 degrees. The mother reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable. She reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable. She reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable. She reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable.

Pediatrician 1 examined the child and noted she was congested and pale. His assessment was upper respiratory infection/allergic rhinitis, and he gave a prescription for Rhinocort and Zyrtec.

On January 17, the mother called the pediatrician reporting that the child was complaining of muscle aches in the thighs, calves, and knees. The on-call physician, Pediatrician 2, advised that it was probably a viral illness. He suggested the child be seen the next day or taken to the emergency department (ED) if her symptoms worsened.

She reported that her daughter no longer had fever, but was now complaining of knees and ankles hurting and that it hurt to walk. The patient was scheduled for an appointment with Pediatrician 3. Pediatrician 3 saw the child and noted she would not walk on her left leg. The complaints of pain involved the left leg. The child would cry when anyone touched her and tensed up and resisted movement when Pediatrician 3 tried to move her legs.

An appointment was scheduled at 1:30 p.m. with Pediatrician 4. At 12:40 p.m., the patient was more uncomfortable. She reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable. She reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable. She reported a swollen, rock-hard area between the elbow and shoulder and that the child was more uncomfortable.

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Following her discharge, the patient was seen by the orthopedic surgeon. He reported that she was walking well and that her knees were virtually normal, although there was some synovitis of her left knee.

Allegations

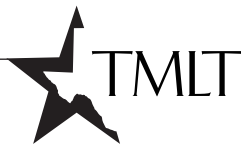
The plaintiff's case targeted the delay in obtaining the lab results and delay in initiating antibiotic therapy.

Legal implications

The plaintiffs obtained expert testimony from pediatric infectious disease who were critical of the defendant's actions. One

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the Reporter



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H[SHUW WHVWLÀHG WKDW have been ordered on a stat basis or the patient should have been sent to a facility that could turn the lab within one hour. Further, since the lab results were not back the following morning (January 19), the lab request should have been changed to stat for two reasons: the phone call reporting the patient's worsening condition and the negative x-ray report. Additionally, the patient should have been re-examined after the call on January 19.

According to the testimony of a lab technician, ordinarily lab results are reported within 24 hours and sometimes earlier. If lab work is ordered on a stat basis, arrangements are made so that it almost always reports in 4 hours. There was no explanation of why the pediatrician ' V RIÀFH G receive the lab results until January 21. If ordered on a stat basis, the lab drawn on January 19 would have been reported on that day. If ordered on a stat basis and prioritized over the x-rays, the lab would have UHSRUWHG EDFN WKH HYH

Another plaintiff ' V H[SHUW WHVWLÀHG earlier intervention would have prevented the patient's condition and lengthy hospitalization. Had antibiotics been given 24 hours earlier, they would have completely

prevented the patient's condition and given 12 hours earlier would have dramatically reduced the severity of the condition. The expert could not say with reasonable medical probability that the patient was septic or infected when seen by Pediatrician 3 on the WK EXW VKH ZDV GHÀQL 19th when the labs were drawn. The plaintiffs also used the nurse's notes from the January 19th phone call to imply that even a triage nurse questioned whether antibiotics should have been started. However, the QXUVH WHVWLÀHG each only was the signal that these questions were directly asked by the parent.

The three pediatric consultants who reviewed this case for the defense were generally critical of the defendant's actions. Primary criticisms included: failure to obtain vital signs, particularly temperature, LRQQ QVWKH -DQXDUV\ WK YLVV the lab in a stat fashion; failure to change the priority of the lab and re-examine the patient after the call of January 19. However, the consultants who reviewed this case questioned whether any delay in treatment contributed to the child's outcome. The defense was able to draw on behalf of the pediatrician. Although supportive, their opinions were subjected to strong cross-examination.

Disposition

The case against Pediatrician 3 and the group was settled during trial.

Risk management considerations

Every practice needs a protocol for prioritizing tests and a follow-up process to assure timely reports and continuity of care. Any delay in this protocol can lead to serious and unintended consequences. Of note in this claim is the number of physicians involved in the child's care over seven days. Although only Pediatrician 3 was sued, four physicians and a nurse were part of the team responding to the reports and concerns of the patient's mother. With multiple physicians in the picture, was one keeping abreast of all the developments in this child's clinical condition? Were her medical record and pending lab reports in a high priority triage status? The case was a wake-up call. However, hindsight affords the opportunity to address prudent risk management practice and the chance to evaluate and reinforce the commitment to implement and consistently follow protocols in every practice.

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