

# the Reporter

by Dana Leidig

*Retainer practice, boutique care, concierge medicine — these terms all describe an emerging trend in patient-financed medical care that is organized enough to have its own association, the Society for Innovative Medical Practice ([www.conciergephysicians.org](http://www.conciergephysicians.org)). Whether or not this new way of practicing medicine will serve patients' health care needs more effectively, provide physicians with greater job satisfaction, or contribute positively to an overburdened health care system in the long term, is speculative. This article will look at the concierge medicine model from the perspective of the patient, the physician, and organized medicine.*

## From then to now

The concept of patient-financed medical care is not new. In addition to accepting monetary payment, early physicians often treated patients in exchange for goods or services. In the early 1900s, tax- and employer-supported health insurance arrived, followed by the Social Security Act in 1935. Thirty years later, Medicare and Medicaid (Titles 18 and 19 of the Social Security Act) were approved to cover the medical needs of citizens over age 64. Along with publicly funded programs, employers began offering health insurance as a benefit to employees. Traditional health insurance evolved into today's managed care model, where both government and private insurers contract with or directly employ physicians. Under managed care, physicians are prohibited from collecting payment from patients except for deductibles, co-pays, or uncovered services.

Over time, physicians have become dissatisfied with managed care. With no control over the pricing of their services or the reimbursement practices of managed care organizations, they are fed up with the system. It is not uncommon for physicians to report that they must regularly see 20 to 30 patients per day to earn enough to meet the costs of running their medical practice. Some physicians describe this as "hamster care,"<sup>1</sup> running on the wheel trying to see as many patients as possible rather than delivering the personal, high quality medical care they envisioned as medical students.



## Concierge medicine a new specialty?

"Overcrowded practices, low reimbursement rates, excessive red tape and the rapid-fire pace of patient exams" have led to pervasive job dissatisfaction among primary care physicians.<sup>2</sup> In the July 2002 *The Journal of Family Practice*, 27% of physicians said that they might leave their practices within two years.<sup>3</sup>

Instead of continuing to run in circles, some physicians have embraced a new model of health care — concierge medicine. In a concierge practice, patients pay the physician a yearly "membership fee," and in return the patient receives certain extra services such as longer appointment times or same-day appointments.

Concierge physicians believe this approach allows them to see fewer patients and work in smaller practices

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where they can focus on the doctor-patient relationship. According to *American Health Line*, nearly 200 physicians have set up concierge practices (out of approximately 850,000 physicians nationwide.)<sup>4</sup> Although this is not an overwhelming number, concierge medicine is a new concept. How large it will grow remains to be seen.

### Patients want greater access

Not only are physicians interested in the benefits of concierge medicine, but patients may be driving the trend to gain greater access to the physician of their choice. With their membership fee — which can range from \$1,000 to \$20,000 annually depending on the services offered and the number of patients — the patient receives special services or uncovered extras which may include:

- same day appointments or guaranteed next day appointments;
- on-time appointments and extended appointment hours, including Saturdays;
- 24-hour access to the physician, either by cell phone, home phone, or pager;
- house calls;
- coordination of care with specialists;
- accompaniment to appointments with specialists and to hospitals, when necessary;
- preventive health and wellness advice;
- telephone and email consultations;
- physicals and free check-ups;
- attractive, less crowded waiting rooms; and
- spa amenities.

Patients are expected to retain health insurance for hospitalizations, laboratory and diagnostic work, and specialty care.

Patients who are willing and able to pay for this additional level of service say they are doing so to return to the quality of medical care they remember from the past, before managed care. The “Marcus Welby model” of a physician from the 1960s has not lost its appeal. Dr. Welby appeared each week on television, visiting with patients, responding to their needs and, in the process, securing their affections and respect.<sup>5</sup> These scenarios are unlike those found in a typical medical practice today where patients may find it difficult to even get an appointment. When they do get in, they may see a physician who is not their regular doctor and who has only a few minutes to discuss their health concerns. The concierge practice model can solve these problems for some patients.

But where does concierge medicine leave those patients who are insured but cannot afford these extra fees? What if a patient does not want to change physicians but chooses not to pay for concierge services? What about Medicare patients? Patients who are undergoing treatment, who cannot afford to pay for concierge services or who choose not to be a part of the concierge practice should not be abandoned or feel that their continuity of care has been compromised. These patients should receive reasonable assistance, including referrals, with locating a new physician. They should continue to be seen until they find another physician. A physician in concierge practice can continue to see Medicare patients, but must fully comply with Medicare law.<sup>6</sup>

### Ethical and moral considerations

Clearly, the concept of concierge medicine raises ethical considerations. One of the main causes for concern is that this practice model encourages a two-tiered economic system — those who can pay for special services and those who cannot. Those who cannot pay or who choose not to pay have limited access to care. According to *Managed Care Magazine*, concierge medicine “makes standard aspects of care into special services,” and causes “economic and access issues” for some patients while providing wealthier patients with greater convenience and concierge physicians with enhanced income.<sup>7</sup> Additionally, when concierge practices limit the number of patients based on economic factors — the ability of the patient to pay extra — physicians in traditional practices must take on the non-participating patients, thus increasing the burden to their practice.

To address the growing concerns about concierge practice, the moral and ethical obligations of physicians to the community, and physicians’ ethical duty to provide medical care to the indigent, the American Medical Association issued guidelines for boutique practices in June 2003. These standards include:

- Both parties must agree to — and be clear about — the terms of the relationship. Patients who wish to opt out should be able to do so without hassle or financial penalty.
- Retainer-style practices should not be marketed as providing better diagnostic and therapeutic services.
- Doctors must help transfer — at no charge — non-participating patients to other physicians. If no others are available, a physician “may be ethically obligated to continue caring for such patients.”
- Doctors must be honest in billing third-party payers.
- Starting a retainer-style practice does not exempt physicians from caring for those in need, especially those in need of urgent care.<sup>8</sup>

A copy of the AMA’s guidelines for concierge practices is available by calling 312-464-4823 or emailing [ceja@ama-assn.org](mailto:ceja@ama-assn.org).

### Physicians looking for greater balance

More control over their practices, more time to spend with patients and with family, better income, and fewer hassles are all appealing aspects of a concierge practice. However, before deciding to convert a traditional medical practice to the concierge model, carefully evaluate the reasons for the change. A reasonable number of patient appointments, a better income, and greater job satisfaction are the main reasons cited by physicians who decide to make the switch. Interestingly, primary care physicians are not the only physicians experimenting with concierge medicine. Specialists such as cardiologists, pediatricians, dermatologists, and obstetricians-gynecologists are exploring aspects of the concierge model.<sup>9</sup>

Launching a concierge practice takes time, money and marketing skills. Some physicians employ practice management companies to help convert their current practices, while others join an existing network of concierge physicians. MDVIP is a national practice management network based in Florida. Their network is adding up to six new physicians per month and they have plans to expand to hundreds of primary care physicians. For the use of their services, MDVIP charges physicians an ongoing service fee based on a percentage of each patient’s annual membership fee. MDVIP’s well-known

concierge practice design has also served as a practice model for 52 physicians in several states.<sup>10</sup>

For physicians who want to launch a concierge practice on their own, secure the help of a knowledgeable consultant and consider the following steps.

- Survey your patients to see what special services are most important to them. What are they likely to pay extra for? Your survey may also help determine patient loyalty to give you an idea how many patients are likely to follow you into your new practice.
- Develop a list of services and your fee structure based on your current patients' needs. Determine your annual fee and clearly articulate the medical and non-medical services you will provide for this fee.
- Work with an experienced health care attorney who is familiar with setting up concierge practices to ensure you are following federal and state laws.
- Create marketing materials that will convey your new practice image and clearly explain your new services to current patients.
- Decide if you will continue to participate in any managed care plans. If yes, explain your new practice model to these health insurers to ensure you are not violating any of their rules or contractual terms. Medicare and most private insurers will not reimburse the annual membership fee or for services not normally covered. To avoid possible legal problems, clearly distinguish between those services and procedures billed to the insurer and those extra concierge services that are covered by your membership fee.
- Send a letter to your patients explaining the changes you will be making in your practice and the timetable for those changes. It is important that patients who are undergoing treatment, who cannot afford to be part of the new practice, or who choose not to be part of the new practice do not feel abandoned or that their continuity of care has been compromised. Assist these patients in finding a new physician by giving them adequate notice and any needed referrals. Be prepared for a few angry letters or phone calls as well as expressions of support.
- Schedule follow-up meetings with patients to explain the new, expanded level of service and to answer any questions.

According to MDVIP, only a small percentage of concierge-style practices will be successful. The physicians with the greatest chance for success are those who already have strong relationships with their patients, who have a strong desire to improve their own "quality of life," and who begin their new practice with a well-developed strategic business and marketing plan. Even when all of these things are present, failing to comply with regulatory rules for government or private health plans could cause a concierge practice to stumble.<sup>6</sup> When developing the new practice, proceed with caution and patience. Rick Goldman, MD, a family physician who changed to concierge practice in 2002 says he could not be more pleased. "I look in the mirror every morning, and I am so happy I did this."<sup>10</sup>

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Dana Leidig can be reached at [dana-leidig@tmlt.org](mailto:dana-leidig@tmlt.org).

# Medical care for **minors**



## *consent, communication among major issues*

### **Objectives**

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

1. Identify who is a minor and when the minor can consent to treatment.
2. Discuss issues relating to vaccinations such as liability, documentation and exemption for reasons of conscience.
3. List current issues and concerns with psychotropic medications and minors.
4. Describe techniques for communicating with adolescents.

### **Course author**

Nancy Steinmacher is a risk management representative at TMLT.

### **Disclosure**

Nancy Steinmacher 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 April 1, 2005, and expires on April 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**

Health care delivery is laden with challenges, and one of the more complex challenges is providing health care to minors.

Whereas children and younger adolescents will most likely have an adult (whether parent or guardian) to advocate for them, older adolescents may be in a position to play a more active role in their health care and treatment planning. Physicians are faced with the challenge of balancing the minor's autonomy, parental rights, and the law.<sup>1</sup> Knowing, when, where, and with whom to share information, and from whom to get consent are some of the demanding areas for physicians and their staffs.

This article will discuss these consent issues and will also address two other complex topics for physicians who treat minors: vaccinations and the prescription of psychotropic medications.

### Definition of a minor

Now that the physician-patient relationship has evolved from paternalism to egalitarianism, physicians and patients typically work together to make health care decisions.<sup>1</sup> Physicians educate patients on treatment options and the associated risks and benefits. Patients use this information to make informed decisions about the treatment options most appropriate for their lives and values. As a rule, minors are considered incompetent decision makers and cannot make health care decisions or give informed consent on their own behalf.

In the state of Texas, a minor is anyone under 18 years of age, who is not and has not been married, or who has not had the disabilities of minority removed for general purposes by a court.<sup>2</sup> Consent would, therefore, fall to the parent or legal guardian in most situations.

### Consent for the treatment of minors

In 1995 the Texas Legislature made changes to laws governing the dissolution of marriage and child custody. As a rule, both divorced parents have joint custody and the right to consent to medical, dental, and psychological care of their children. Both parents also have the right to access all medical records.<sup>3</sup> Occasionally, the court may limit the rights of one parent.<sup>3</sup> If there is any doubt about who may provide consent or access the records, it is appropriate to request a copy of the divorce order. For example, if a parent who has not been involved in the child's care suddenly appears at the office and there has been a divorce, it may be prudent to request a copy of the court order.

When parents cannot be contacted for consent, the following persons (or entities) may consent to medical, dental, psychological, and surgical treatment as long as actual

notice to the contrary has not been given:

1. a grandparent of the child;
2. an adult sibling of the child;
3. an aunt or uncle of the child;
4. an educational institution in which the child is enrolled that has written authorization to consent from a person with a right to consent; and
5. an adult who has actual care, control, and possession of the child and has written authorization to consent from a parent. (For a complete list please see Texas Family Code Section 32.001.)

In order to implement prudent risk management and to help alleviate difficult situations, physicians may wish to develop a consent form in which the parents outline who may consent to treatment if they are unavailable. The consent form should contain: the child's name and date of birth; information about allergies or chronic medical conditions; the parents' names and addresses; the dates the consent is in effect; insurance information; and the name, address, and phone number of any person who can consent if the parents are unavailable. This consent form can alleviate treatment delays if the child is accompanied by someone other than the parents. At the very least it will save staff time in locating the parent. (Please see sample consent form on page 10.)

### Exceptions: when minors can consent

Many minors have the capacity, and indeed the right to make health care decisions. The special conditions under which a minor may make their own health care decisions are outlined in accordance with Texas Family Code Section 32.003, Consent to Treatment by Child. It states minors can consent to health care decisions under several circumstances.

- A minor on active duty with the armed forces of the United States can consent to any medical treatment.
- A minor who is 16 years of age or older, residing apart from his or her parents, and managing his or her own finances, regardless of the source of income, can consent to any medical treatment.
- A minor can consent to diagnosis and treatment of any infectious, contagious, or communicable disease that is reportable to the Texas Department of State Health Services.
- A minor who is unmarried and pregnant can consent to treatment of pregnancy including any hospital, medical, or surgical treatment other than abortion.
- A minor can consent to examination

and treatment for addiction, dependency, or any other condition related directly to drug or chemical use.

- A minor can consent to counseling for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse.
- A minor who is suffering from what reasonably appears to be a life-threatening injury or illness and whose parents, managing or possessory conservator, or guardian, is not present can consent.<sup>4</sup>

In relation to the above exceptions, there are several points to consider regarding a minor's limited ability to make informed consent decisions.

While a minor may consent to all necessary treatment during her pregnancy, except abortion or the morning-after pill, her continued right to consent to medical treatment terminates upon the completion of pregnancy-related care. At this time, informed consent reverts back to the minor's parents or legal guardians, including birth control. This point is easily confused, as the minor, now also a parent, can consent to her child's care but not her own.

It should also be noted that while a minor may appear for treatment without parental consent, parents may request the medical records from the visit if the treatment becomes known to them (i.e. insurance explanation of bill).<sup>3</sup> A good risk management practice is to have staff obtain the patient's parents' names and addresses on the initial visit. If the parent requests the record, office staff should require the parent to come to the office rather than provide the information over the phone. If the parent is unknown, request a photo I.D. to confirm the parent's identity.

To validate the autonomy of a minor seeking health care concerning family planning or reproductive decisions, physicians must be aware of alternative community resources to provide the minor with treatment options. One option physicians can offer minors who desire confidential preventive health services is Title X health care providers. Initiated in 1970, Title X, was established to increase access to family planning and other preventative health care services such as screening for sexually transmitted diseases, health education, and referrals for other health and social services.<sup>5</sup> These clinics receive federal funds through Title X of the Public Health Service Act and are exempt from state law.<sup>6</sup>

Regarding abortion and a minor's limited ability to make informed consent decisions, Texas is a parental notification state and

requires that before performing an abortion, a physician must inform at least one of the minor's parents or legal guardians. Texas Family Code Section 33.002 cites the following two requirements:

1. the physician gives at least 48 hours actual notice to a parent, a court-appointed managing conservator or legal guardian; or
2. the minor has obtained a court order to waive the notification pursuant to Texas Family Code Section 33.003.

A court will take into consideration a minor's appeal if she feels that involving her parents or legal guardian in her decision to have an abortion may jeopardize her welfare. The Texas law has been in effect since January 1, 2000.<sup>7</sup>

### In the news

In 2000, a Houston physician performed an abortion on a woman reporting to be 18 years old. In actuality, the patient was seven weeks shy of her 18th birthday. She presented fake identification to the physician's office in order to obtain an abortion. In 2004, the patient and her father brought a civil suit against the physician for not confirming her age and contacting her parents before the procedure, raising the issue of due diligence. A jury found that the physician had performed the abortion in violation of the Texas parental notification law; however, no funds were awarded to the patient or her father. This case illustrates the importance of having a procedure in place to confirm the age of patients.<sup>8</sup>

### Vaccination

The vaccine is considered one of medicine's greatest achievements, yet the possibility of vaccination-related injuries to children has been a concern since the 1980s. At that time, manufacturers threatened to stop making vaccines unless Congress passed legislation protecting them from vaccine-injury lawsuits. Parents then lobbied for compensation and to protect their right to sue vaccine manufacturers if federal compensation was denied.

To reinforce public trust in the national vaccine program and to ensure the availability of vaccines, a national Vaccine Injury Compensation Program (VICP) became effective in 1988. This program was designed to be a no-fault, non-adversarial alternative to litigation, and was part of the National Childhood Vaccine Injury Act of 1986.

Currently, adverse events following vaccinations are monitored through the Vaccine Adverse Events Reporting System (VAERS), which is operated by the Food and Drug Administration (FDA). Under the law, doc-

tors are required to record any vaccine adverse events in the child's medical record. Doctors must also report any hospitalizations, injuries, or deaths following vaccination to the VAERS. The law also requires doctors to provide parents with a Vaccine Information Statement (VIS) before the child is vaccinated with any vaccine covered by the VICP. The VIS outlines the risks and benefits of the vaccine and provides information about the VICP.

The VISs are produced by the Centers for Disease Control and Prevention (CDC), and all current VISs are available on the Internet in a variety of languages at the National Immunization Program ([www.cdc.gov/nip](http://www.cdc.gov/nip)); the Immunization Action Coalition ([www.immunize.org](http://www.immunize.org)) or at the Texas Department of State Health Services ([www.tdh.state.tx.us/immunize/vischart.htm](http://www.tdh.state.tx.us/immunize/vischart.htm)).

Physicians are not required to provide VISs for influenza, hepatitis A, pneumococcal polysaccharide, meningococcal, or anthrax vaccines, unless the vaccines are purchased through a CDC contract. However, their use for these vaccines is strongly encouraged.<sup>9</sup> While it is good risk management to have the parent or guardian sign the vaccination record to indicate consent, the health care provider is required to record the edition date of the materials and the date these materials were provided.<sup>9</sup>

Non-parents can give consent for immunizations when a parent or guardian cannot be located.<sup>12</sup> The persons or entities who can consent include:

- a grandparent of the child;
- an adult brother or sister of the child;
- an adult aunt or uncle of the child;
- a stepparent of the child;
- any educational institution in which the minor is enrolled and has written authorization from persons having power to consent;
- another adult who has care, control and possession of the minor and has written authorization from the person authorized to consent;
- a court who has jurisdiction over the child, while a divorce or other custody-type suit is pending;
- an adult who is the child's primary care giver and has written authorization from the parent or other person authorized to consent.

The state's efforts to educate the public on the benefits of vaccinations seems to be working. In 2000, Texas ranked last among the 50 states in vaccination levels for children aged 19 to 35 months.<sup>10</sup> By 2002 Texas ranked 42nd.<sup>11</sup> But with the increased efforts comes a new vaccine exemption law allow-

ing parents to exercise a conscientious belief exemption to vaccination.

When HB 2292 was signed into law by Governor Rick Perry, Texas joined 18 states, including every state bordering Texas, allowing conscientious exemption. HB 2292 also prohibits any health and human service agency from taking punitive action against a parent for not immunizing their child. Children are allowed admission to any elementary or secondary school or any institute of higher education if an affidavit signed by the physician states the vaccination poses a significant health risk to the child or if an affidavit signed by the parent or guardian declines vaccination for reasons of conscientious belief. This law emphasizes the significance of voluntary decision-making.

Should parents choose not to have their child vaccinated, the physician can provide information on how to obtain an Exemption for Reasons of Conscience. A vaccine exemption affidavit may be requested by mail or fax and should include the child's name and date of birth. Requests should be mailed to: Texas Department of State Health Services, Immunization Branch, 1100 West 49th Street, Austin, TX 78756 or faxed to 512-458-7544.

### Psychotropic drug warnings

The use of psychotropic medication by minors has become prevalent and controversial. It is estimated that hundreds of thousands of adolescents — and even some preschool-age children — take some type of antidepressant.<sup>13</sup> Approximately 15% of school-age children have been placed on mind- and behavior-altering substances, such as Ritalin or Adderall to treat attention-deficit/hyperactivity disorder (ADHD). Likewise, increasing numbers of children and adolescents are being given prescriptions for antidepressants, such as Prozac and Zoloft, by primary care physicians.

Many child psychiatrists urge caution, indicating that medication should not be used as a "quick fix," but combined with other types of therapy, such as individual or family counseling. A number of physicians specializing in pediatric psychiatry have also suggested that some children and adolescents are being treated with these medications without a thorough assessment of their symptoms. When faced with the complicated task of diagnosing and treating a psychiatric illness, a physician may inadvertently become more vulnerable to liability.

Family physicians, for reasons ranging from managed care arrangements to physician availability, are increasingly dispensing antidepressants to children. However, most mental health professionals concur that

depression is best diagnosed and treated with a comprehensive plan that includes adjunct treatment (such as cognitive behavioral therapy), ongoing evaluation, and periodic medication monitoring. For a physician who is knowledgeable of and comfortable with prescribing psychotropic medications, it may be a good risk management practice to recommend a psychiatric consultation, especially if symptoms are not transient or in direct correlation to psychosocial factors.

A misdiagnosis can have serious results. For example, a child who has an underlying bipolar illness and not just depression is at greater risk for developing mania while taking an antidepressant.<sup>13</sup> Also, a younger patient who may be developing symptoms in response to a developmental issue may present symptoms that appear to meet diagnosis criteria, but do not necessarily require medication to treat. Again, a physician may face time constraints when addressing the broad spectrum of psychosocial factors that may be affecting the patient. Therefore, it is important to actively involve and educate parents regarding their child's condition and treatment options. Regarding mental health issues, it may be prudent for a physician to be aware of mental health providers practicing in the community as well as other resources available to ensure that the patient is accurately diagnosed and adequately treated.

In working with minors, physicians may be challenged by external pressures to provide a predetermined course of treatment. For example, a physician may be presented with a provisional diagnosis that has been considered before the initial consultation, such as a parent suggesting that his or her child may be suffering from anxiety, depression, or a form of attention deficit disorder. While it is important not to dismiss feedback or suppositions, it is equally important to gather as much information as possible from the patient and collateral resources in order to formulate a concise diagnostic impression.

Conversely, both patient and parent may be resistant to feedback that suggests a particularly stigmatizing diagnosis or treatment plan. Taking the time to develop an effective relationship with both patient and parent can facilitate the process of obtaining informed consent for treatment. As mentioned earlier, it may be prudent to refer a patient with a complex or atypical presentation for a psychiatric consultation. The same might apply if a patient is not responding as anticipated to a prescribed psychotropic medication. Some physicians may feel pressured to treat psychiatric issues due to a number of factors, including reluctance on the part of the patient to consult

with another physician, or difficulty gaining access to a psychiatric consultation due to limited or restricted resources.

Physicians are not the only ones feeling pressure to treat children with psychotropic medications. Across Texas, parents have reported that school officials have threatened them with Texas Department of Protective and Regulatory Services (DPRS) investigations if they refused to seek psychiatric treatment for their children's behavioral problems. In response to this, the 78th Texas legislature passed House Bill 1406, which prohibits certain school district employees from recommending that a student use a psychotropic drug or have a psychiatric evaluation or examination. It also prevents schools from prohibiting a child from attending a class or participating in a school-related activity if the parent refuses consent for the administration of a psychotropic drug or a psychiatric evaluation or examination. It does not prohibit a school district employee who is a registered nurse, advanced nurse practitioner, physician, or certified or appropriately credentialed mental health professional from recommending that a child be evaluated by an appropriate medical practitioner.<sup>14</sup>

Additional legislation ensures that a refusal by a parent or guardian to seek a central nervous system stimulant or other drug for treatment of ADHD would not by itself constitute neglect as defined under Section 261.001 of the Texas Family Code.<sup>15</sup>

#### In the news

In 2001, 12-year-old Christopher Pittman shot and killed his grandparents as they slept. He then set fire to the house and stole the couple's car. When he was found 30 miles away, he claimed that a man killed his grandparents and kidnapped him. He later confessed to the killings. The boy's father thinks his son killed because the antidepressant Zoloft clouded his sense of right and wrong. Pittman had been hospitalized in Florida one month before the murders for suicidal ideation and was initially placed on Paxil, before being changed to Zoloft.

In the three years since the shootings, the FDA has become increasingly wary of doctors prescribing Zoloft and other antidepressants for adolescents. In October 2004, the FDA issued a black box warning, the strongest government warning short of a ban, about the increased risk of suicidal thoughts and behavior in children and adolescents being treated with antidepressant medications. While Pfizer addressed suicide attempts on the company's web site, they denied a "statistically significant difference"

in children nonusers and users of Zoloft. However, Pfizer's statement does not discuss a connection between violent behavior and Zoloft.

Pittman's attorneys claimed the medical research was available to support the "Zoloft defense." During the murder trial, they argued that Pittman was "involuntarily intoxicated" by the drug. The jury was not convinced and Pittman was found guilty and sentenced to 30 years in prison.

The "Zoloft defense" has worked in only one criminal case. Last April, a jury in Santa Cruz, California acquitted a man of attempted murder because of a reaction to Zoloft.<sup>16</sup>

Due to this heightened concern and history of litigation, it becomes increasingly important for a physician to exercise caution when treating minors who present with psychiatric or mental health issues. Discuss treatment risks and options as well as adjunctive treatment strategies with the parents or guardians.

#### Communicating with adolescent patients

Communicating effectively with adolescents can be challenging, but finding a way to negotiate this obstacle can help promote healthy adolescent development and compliance with treatment recommendations. Effective communication can be more difficult with adolescents as they typically require an emotional bond, however brief, with the treating physician.<sup>17</sup> Therefore, building an early rapport with an adolescent patient can enable an effective working relationship. In general, adolescents respond to adults who are non-judgmental and straightforward and who will take the time to validate their concerns.

Adolescents are beginning to develop abstract thinking, giving them the ability to perceive themselves and situations in shades of gray. Adolescents benefit from adults who will listen to them, validate their concerns and help them develop their ability to reason and solve problems in a rational manner. As this occurs, adults are better able to coach them to use services or information to better advance their health.

Further complicating the communication process with adolescents is their varying capacity to think, rationalize, and comprehend the implication of treatment recommendations. During a typical adolescent's development, it is normal for them to verbalize a contrary opinion from adults, particularly those they perceive as being in a position of authority, and to sometimes argue for the sake of arguing. This is the adolescent's way of formulating a sense of self and control over his or her life. Additionally, ado-

lescent behavior is commonly marked by impulsive or rash decision making. An intuitive physician can help to present a broader range of options without devaluing the adolescent's initial choice. If a physician is able to recognize this pattern of communication and interaction, he or she will be better equipped to overcome obstacles.

Upon entering the health care system, an adolescent may perceive that his or her contact with the physician is confidential. Presenting their health concerns may be difficult for the minor patient, and the physician may be the first adult aware of the minor's situation. Even though involving the parent in the treatment of the minor is mandated by law, the physician can promote a collaborative approach to treatment, which in turn may increase compliance with treatment.

During the consultation stage, it is important to take into consideration the context of the patient's complaint. Adolescents may present with a variety of symptoms that are difficult to accurately diagnose without adequate background or relevant psychosocial considerations. For example, an adolescent complaining of a stomachache may not give enough information to make a clear diagnosis. An adolescent may formulate a cause and effect relationship that may or may not help a physician develop a clear perspective on the presenting problem.

Collateral contact becomes an important element in effectively diagnosing and treating minors. Whenever possible, parents should be an active part of the treatment plan and follow up. In order to make an informed decision, both minor and parent should be educated on the treatment options available and on the potential outcomes and risks.

Informing the adolescent patient solely of the negative health consequences of high-risk behavior generally is not enough to inspire or motivate the adolescent to cease the behavior. Adolescents typically harbor more fear of the negative social consequences than the health risks of their behavior. One way to provide more effective guidance to adolescent patients is to expand the range of choices available to them. This allows an adolescent to weigh the options and consider the consequences, therefore empowering them to take an active role in their health and treatment planning. If this is accomplished, it increases the opportunity for the physician to provide direction and guidance.

Discussing difficult issues such as birth control, depression, or drug use usually requires time and trust. Working within a managed care environment may make it difficult for physicians to spend adequate

time with their adolescent patients. However, if a physician or a specific staff person is available to the adolescent, this can assist with developing trust and increasing communication which can facilitate increased efficacy of the time spent with the adolescent patient.

### Conclusion

Being aware of laws that impact and define health care delivery to minors, as well as having structured and consistent policies and practices related to minors, will help decrease risk. In addition, seeking ways to develop a mutual working relationship with minors and their parents or guardians will increase the potential for effective treatment, while decreasing the risk of liability.

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Nancy Steinmacher can be reached at [nancy-steinmacher@tmlt.org](mailto:nancy-steinmacher@tmlt.org).



# SAMPLE

## Authorization for medical treatment of minors

If your child needs medical, dental, or hospital services a parent must give permission. It's the law. What if you cannot be reached to give permission? A child may be treated without parental consent when a physician determines a true emergency exists. A true emergency means the child needs immediate medical care and attempting to obtain parental consent would result in a delay that could increase the risk to the child's life or health.

Sometimes, however, a child may need unexpected care which is not a true emergency. In such cases, attempting to contact a parent for permission can delay treatment and create unnecessary anxiety for the child. To alleviate treatment delays, make sure your child's caregivers know how to contact you at all times. When it may be difficult to contact you, you can appoint an adult to consent to medical treatment for your child.

This document allows you to appoint relatives, friends, caregivers — anyone 18 years of age or older — to consent to medical treatment for your child. Complete this form and give it to the adult(s) who have your permission to seek medical treatment. A copy will be placed in your child's medical record. If your child needs medical care, the designated adult should present this document at the time of treatment. It is especially important to prepare this form for those occasions when we may be unable to reach you.

| Name of minors | Date of birth | Allergies/special conditions |
|----------------|---------------|------------------------------|
| _____          | _____         | _____                        |
| _____          | _____         | _____                        |
| _____          | _____         | _____                        |

I/we, being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint

| Name  | Address | Phone number |
|-------|---------|--------------|
| _____ | _____   | _____        |
| _____ | _____   | _____        |

to authorize unexpected medical, dental, surgical care, and hospitalization for the above named minor(s) during the period of my/our absence, from \_\_\_\_\_

This document shall be presented to a physician, dentist or appropriate hospital representative at the time any unexpected medical, dental, surgical care or hospitalization may be required.

|   |                  |
|---|------------------|
| _____<br>Signature of parent or guardian/date | _____<br>Address |
| _____<br>Signature of witness/date            | _____<br>Address |

Insurance coverage for the above named minor(s) — please include insurance company and policy information

\_\_\_\_\_

Physician's name and phone number

\_\_\_\_\_

*All articles and any forms, checklists, guidelines and materials are for general information only, and should not be used or referred to as primary legal sources or construed as establishing medical standards of care. They are intended as resources to be selectively used and always adapted — with the advice of the organization's attorney — to meet state, local, individual organizations and department needs or requirements. This form is distributed with the understanding that Texas Medical Liability Trust is not engaged in rendering legal services. © 2005 TMLT*

# closed claim study

## Failure to prescribe appropriate medication and diet

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 29-year-old man was brought to the emergency department of a regional medical center. The patient's chief complaint was bilateral leg weakness. He had a history of poorly controlled hypertension, chronic headaches, chronic fatigue, post-traumatic stress disorder, bipolar depression, and irritable bowel syndrome. Lab studies ordered in the ED revealed an extremely low potassium level (1.3 mEq/L). The ED physician contacted the on-call internal medicine physician who ordered the patient's admission and potassium replacement.

### Physician action

The internal medicine physician saw the patient the next morning. He ordered a repeat potassium study, and requested a nephrology consult to help determine the cause of the patient's hypokalemia. The nephrologist ordered several diagnostic studies and ultimately diagnosed the patient with a rare condition known as thyrotoxicosis. The nephrologist consulted an endocrinologist to assess for hyperthyroidism and to assume the management of the patient's endocrine disorder. The endocrinologist made the diagnosis of thyrotoxic hypokalemic periodic paralysis (TPP), a rare condition characterized by recurrent episodes of motor weakness associated with hyperthyroidism. The nephrologist and the endocrinologist felt the patient could be treated on an outpatient basis.

The internal medicine physician discharged the patient with the following instructions: follow up with the endocrinologist in one month for a thyroid scan; see the nephrologist within two weeks; and call the internal medicine physician's office to schedule an appointment immediately after arriving home. The patient was discharged on a high-potassium, low-sodium diet and was given information on this diet. The nephrologist prescribed the beta-blocker Propranolol for treatment of the thyrotoxicosis. It was later discovered that this prescription was filled, but not taken by the patient.

Three days after his discharge, the patient was brought back to the ED by ambulance. Seven hours before becoming ill, he had eaten a large, carbohydrate-rich meal. His potassium level on admission was 1.3 mEq/L. While in the ED, the patient suffered cardiac arrhythmias. Resuscitative efforts lasted more than one hour, but were unsuccessful. An autopsy was performed and the pathologist concluded the patient died as a result of TPP, precipitated by a high-carbohydrate meal.

### Allegations

Lawsuits were filed against the internal medicine physician, the nephrologist, and the endocrinologist. The allegations included:

- failure to timely evaluate, diagnose, and treat the patient's hyperthyroidism and thyrotoxicosis;
- negligence in deferring treatment of hyperthyroidism for two weeks after discharge;
- failure to prescribe the appropriate medication and diet before discharge; and
- failure to provide the necessary counseling and treatment to prevent further drop in potassium level before discharge.

### Legal implications

Defense consultants were supportive of the care given by all three physicians in this case. The physicians successfully diagnosed and treated a very rare medical condition,

one that many physicians may never see. According to nephrology and endocrinology experts, the patient did not need long-term potassium supplementation once he left the hospital because his potassium level stabilized following replacement therapy. Propranolol, which blocks the peripheral action of excess thyroid hormone and reduces the frequency and severity of TPP attacks, was prescribed appropriately. All the experts reviewing this case, including the plaintiff's experts, agreed that if the patient had taken Propranolol as prescribed, he would not have suffered a fatal attack of TPP.

The main allegations against the physicians involved the discharge instructions and the failure to instruct the patient to follow a low-carbohydrate diet. The patient's wife claimed the Propranolol was not taken because there was confusion over the reason for its prescription and that they had not been given a doctor's number to call with any questions. The nephrologist's discharge summary clearly indicated that the patient understood why Propranolol was being prescribed. The discharge instruction sheet, signed by the patient, listed phone numbers for all three physicians, but none of the physicians were ever contacted. The patient also failed to make the follow-up appointments as instructed at discharge.

During the investigation of this claim, it was also discovered that the plaintiff did not follow the low-sodium diet. The patient's wife testified that he consumed 12 soft drinks daily after leaving the hospital. The meal the patient consumed before his death consisted of a fast-food hamburger and French fries.

Regarding the failure to counsel the patient about a low-carbohydrate diet, the plaintiff's internal medicine expert claimed that any physician treating a patient for TPP must advise the patient to reduce carbohydrate intake. Further, the standard of care would require a physician to tell the patient that a high carbohydrate load could increase

*continued on page 14*

# mass litigation alert

## Questions and answers about COX-2 inhibitors

by Scott Allen, JD and Jay H. Henderson, JD

*Editor's note: We continue to receive questions from physicians regarding the use of COX-2 inhibitors. The FDA is analyzing all available information from the most recent studies of Vioxx, Celebrex, and Bextra to determine whether additional regulatory action is needed. In the interim, we have asked two TMLT defense attorneys with experience in mass litigation to answer some common questions about COX-2 inhibitors.*

### Q. What is the status of Vioxx?

**A.** Vioxx was voluntarily removed from the market by Merck on September 30, 2004. Raymond Gilmartin, chairman and CEO of Merck, said the action "best serves the interests of patients . . . [G]iven the availability of alternative therapies, and the questions raised by the data, we concluded that a voluntary withdrawal is the responsible course to take."

According to Merck's announcement and Gilmartin's statements, the withdrawal was based on "new data" received on September 24, 2004 from the APPROVe clinical trial Merck was then conducting. The data from this trial evidently indicated a potential increased risk of cardiovascular adverse events after 18 months of Vioxx treatment.

### Q. Did Merck have information about potential cardiovascular risks before September 2004?

**A.** There have been negative press reports concerning Merck's knowledge of Vioxx's risks and when Merck had this information. According to Merck, however, it was not until late September 2004 that they had the information leading to Vioxx's withdrawal. We do know the following.

The VIGOR study was published in November 2000 in *The New England Journal of Medicine*.<sup>1</sup> In public statements released after VIGOR, Merck "reconfirmed the favorable cardiovascular safety profile of Vioxx" and advised that the study findings were "consistent with naproxen's ability to block platelet aggregation by inhibiting COX-1 like aspirin."

As late as August 2004, Merck issued a press release in which it "strongly disagreed" with data suggesting an increased cardiovascular risk associated with Vioxx and stated

that the company "stands behind the efficacy, overall safety and cardiovascular safety of Vioxx." Thus, it is clear that before Vioxx's withdrawal Merck reassured physicians about the overall safety and cardiovascular safety of Vioxx.

### Q. What is the status of the COX-2 Celebrex?

**A.** Celebrex remains on the market, but the label has been changed. The product labeling now contains information about potential cardiovascular health risks. View the label at: [www.celebrex.com/pdf/Celebrex\\_PI.pdf](http://www.celebrex.com/pdf/Celebrex_PI.pdf). The FDA has produced an "FDA Alert for Practitioners" available at [www.fda.gov/cder/drug/infopage/celebrex/celebrex-hcp.pdf](http://www.fda.gov/cder/drug/infopage/celebrex/celebrex-hcp.pdf) and a "Patient Information Sheet," at [www.fda.gov/cder/drug/infopage/celebrex/Celebrex-ptsk.pdf](http://www.fda.gov/cder/drug/infopage/celebrex/Celebrex-ptsk.pdf). Physicians are encouraged to provide patients with a copy of the FDA's "Patient Information Sheet" on Celebrex.

### Q. What is the status of the COX-2 Bextra?

**A.** Bextra also remains on the market, but it has also been relabeled. The new Bextra labeling includes a black box warning of potentially fatal skin reactions, available at: [www.bextra.com/pdf/bextrapi.pdf](http://www.bextra.com/pdf/bextrapi.pdf). The skin reactions include toxic epidermal necrolysis and Stevens Johnson Syndrome.

The Bextra label has also been revised to include new information about potential cardiovascular risks: [www.fda.gov/cder/drug/infopage/bextra/default.htm](http://www.fda.gov/cder/drug/infopage/bextra/default.htm).

### Q: What was the outcome and meaning of the FDA Advisory Committee's hearings held February 16-18, 2005?

**A.** The FDA Advisory Committee, consisting of physicians and scientists from across the country, met on February 16-18, 2005 to discuss COX-2 inhibitors. At this time it is unclear what the ultimate outcome will be. The Advisory Committee only makes recommendations to the FDA. The FDA will then consider the Advisory Committee's comments in promulgating future regulations. The Advisory Committee voted to allow the continued marketing of Vioxx (17-15), Bextra

(17-13) and Celebrex (31-1). While this vote was "positive" for the COX-2s, several points should be made.

First, the vote for Vioxx and Bextra was quite narrow. As previously noted, Vioxx has been voluntarily withdrawn from the market by Merck and is currently unavailable. While Bextra is still on the market, the manufacturer has added a black box warning about its risks. The vote did nothing to change these facts.

Additionally, while the vote for Celebrex was more positive, the Advisory Committee acknowledged that there were potential cardiovascular risks associated with all COX-2s. Thus, while some COX-2s will remain on the market, new information and warnings concerning cardiovascular risks will most likely be added to the package insert. In fact, there may be black box warnings added to all COX-2s and new information concerning dosage, indicated patient populations, and other issues.

Lastly, there were numerous comments concerning the issue of direct-to-consumer advertising of these drugs. The Committee chairman Dr. Alistair Wood, said "I think the Committee wanted to send a very clear message that direct-to-consumer advertising for these drugs was inappropriate."

Thus, we believe it is important to look beyond a "count the votes" analysis of the FDA Advisory Committee and consider all of the recent information when evaluating future COX-2 prescriptions.

### Q. What is the most recent information on COX-2 inhibitors and can you give us a definite answer about COX-2 risks and benefits?

**A.** There is no definitive answer about the risks and benefits of COX-2 inhibitors. However, we believe the continuing influx of information about COX-2 inhibitors and their potential cardiovascular risks makes future litigation more likely. The February 20th issue of *The New England Journal of Medicine* has published additional information on COX-2s. This issue contains the APPROVe study on Vioxx, information about a clinical study on Celebrex, and additional editorials. While you may consider these articles and comments in their

entirety, we will quote from the “conclusion” of some of these articles.

In one article, the authors report on a double-blind placebo-controlled trial evaluating Vioxx in the treatment of the recurrent neoplastic polyps of the large bowel. The abstract states “Among patients with a history of colorectal adenomas, the use of Rofecoxib was associated with an increased cardiovascular risk.” It was evidently this study that led Merck to voluntarily withdraw Vioxx in 2004.<sup>2</sup>

In another article, the authors report on a clinical trial comparing two doses of Celebrex with placebo for the prevention of colorectal adenomas. The abstract concludes “Celecoxib use was associated with a dose-related increase in the composite end point of death from cardiovascular causes, myocardial infarction, stroke, or heart failure. In light of recent reports of cardiovascular harm associated with treatment with other agents in this class, these data provide further evidence that the use of COX-2 inhibitors may increase the risk of serious cardiovascular events.”<sup>3</sup>

Lastly, in an accompanying editorial Jeffrey M. Drazen, MD states “When the CLASS and VIGOR trials were started, the cardiovascular adverse events were not foreseen. However, when these clinical trials showed an increased risk of myocardial infarction, rather than consider this finding a major danger signal, the manufacturers designed trials to show efficacy for other indications and enhanced the cardiovascular safety monitoring in these subsequent trials. It is a sobering thought that although the number of deaths and cardiovascular events attributable to COX-2 inhibitors remains in dispute, had trials designed to test the question of cardiovascular toxicity directly been launched in 1999 and executed with urgency, substantial morbidity and perhaps a substantial number of deaths could have been prevented. As we apply new science to develop new medicines, we must not forget that our first job is to do no harm.”<sup>4</sup>

Thus, it appears that COX-2 inhibitors carry a cardiovascular risk that was previously unknown to physicians. Many questions remain including: whether there are differences between the various COX-2 inhibitors regarding the potential risks; whether there is a particular dosage/duration associated with this potential risk; and whether there are differences in the risk potential among patient populations. Physicians have yet to receive final answers to these and other questions.

#### **Q: Should I continue to prescribe COX-2s, including Celebrex and Bextra?**

**A.** There is no right or wrong answer that fits every patient, and the new and evolving medical literature on this topic makes infor-

mation on the safety of COX-2s difficult to fully evaluate. However, you may want to consider the following statements about Vioxx and other COX-2s.

An article in *The New England Journal of Medicine* states “We now have clear evidence of an increase in cardiovascular risk that revealed itself in a manner consistent with a mechanistic explanation that extends to all the coxibs.” The author concludes “Selective inhibitors of COX-2 remain a rational choice for patients at low cardiovascular risk who have had serious gastrointestinal events, especially while taking traditional NSAIDs. It would also seem prudent to avoid coxibs in patients who have cardiovascular disease or who are at risk for it.”<sup>5</sup>

*The Lancet* conducted a meta-analysis of 18 randomized controlled trials and 11 observational studies. The authors concluded “Our findings indicate that Rofecoxib should have been withdrawn several years earlier.”<sup>6</sup>

In a letter to the editor published in *The New England Journal of Medicine*, the authors “. . . write to recommend that clinicians stop prescribing valdecoxib (Bextra) except in extraordinary circumstances. We believe the doubts raised about the safety of valdecoxib constitute a potential imminent hazard to public health and thus require attention.” Two of the authors have received consulting fees and/or research support from Merck and/or Pfizer.<sup>7</sup>

*The New England Journal of Medicine* of February 20, 2005 also published an editorial which concluded that “although the cardiovascular risks of COX-2 inhibitors are now more clearly documented, they have not been adequately evaluated in long-term studies in low-risk populations or high-risk populations. The absence of evidence here is not evidence of safety. In clinical trials, NSAIDs, aspirin, and acetaminophen are just as effective as the COX-2 inhibitors. If a COX-2 inhibitor were necessary, patients would have to be informed of the potential risks, and the lowest possible dose should be used for the shortest possible time.”<sup>8</sup>

At the February FDA hearings on COX-2s, Ned Braunstein, senior director of Merck Research Laboratories, suggested the adverse events seen with Vioxx may be evidence of a “class effect.” Braunstein said “We believe the data strongly suggest a class effect from COX-2 inhibitors . . . We would argue that long-term studies are needed” to determine class effects. Further, when he was asked if Merck’s research showed improved pain relief from Vioxx, Braunstein answered “no.”<sup>9</sup>

#### **Q: Do you have any suggestions concerning legal risk protection if a physician chooses to continue prescribing COX-2s?**

**A.** Physicians should keep in mind all the information herein provided, including: the FDA’s “Public Health Advisory on Non-Steroidal Anti-inflammatory Drugs,” located at [www.fda.gov/cder/drug/advisory/nsaids.htm](http://www.fda.gov/cder/drug/advisory/nsaids.htm); and the FDA Talk Paper “FDA Issues Public Health Advisory Recommending Limited Use of Cox-2 Inhibitors” available at [www.fda.gov/bbs/topics/ANSWERS/2004/ANS01336.html](http://www.fda.gov/bbs/topics/ANSWERS/2004/ANS01336.html).

From a defense perspective, document in the patient’s chart that you discussed these risks with the patient. We also urge physicians to have patients sign a written consent such as the FDA’s “Patient Information Sheet,” and place a copy of the signed document in the patient’s medical record.

#### **Q. Some people have said physicians may only be “venue defendants” in any COX-2 lawsuits. (That is, only named in the suit in order to have the case tried in a state court venue) Is this true?**

**A.** We cannot answer why physicians are sued, but we do know that certain plaintiffs’ attorneys have publicly stated that they intend to pursue the manufacturers of COX-2s and the physicians who prescribed the drugs. Therefore, any time a physician is named as a party to a lawsuit it must be taken seriously.

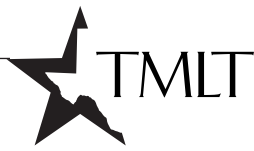
#### **Q. What should I do if I am contacted by an attorney about COX-2 inhibitors or about a patient who has taken COX-2s?**

**A.** Due to the current legal environment and the potential for litigation, if you are contacted by a lawyer representing either a manufacturer of COX-2s or by a potential plaintiff, you should contact TMLT at 800-580-8658 and ask for Erika Castillo or Ginny Markham.

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## closed claim study . . . continued from page 11

the risk of an attack of TPP. Conversely, the defense endocrinologist expert stated the standard of care does not require a discussion of precipitating factors because most cases of TPP attacks are idiopathic. Additionally, if the patient had taken the Propranolol as prescribed it would have prevented the fatal attack of TPP, even in light of the high consumption of carbohydrates. It was also unlikely that the patient would have followed a low-carbohydrate diet because he failed to follow the low-sodium diet.

### Disposition

With his consent, the case against the endocrinologist (who was not a TMLT policyholder) was settled before trial. While disputing the claim, he agreed to a compromise settlement to avoid the uncertainty of litigation involving the death of a young man who was survived by his wife and two young children. How much the sympathy factor would affect the jury could not be predicted. The cases against

the internal medicine physician and the nephrologist were closed without indemnity payment.

### Risk management considerations

Perhaps this study should be viewed as an example of a claim that should never have been filed. An on-call physician and two consultants responded in a timely manner to care for a patient admitted from the ED. A critical potassium level was corrected, the proper diagnosis of a rare disorder was made, and the appropriate medication was prescribed. The death of the patient was the direct result of his noncompliance, the failure to take Propranolol.

Why indemnity was paid on behalf of the endocrinologist is not known. Perhaps, an unwillingness to proceed to trial and present this emotionally charged case in front of jurors led to the decision to settle his case.

*Barbara Rose can be reached at [barbara-rose@tmlt.org](mailto:barbara-rose@tmlt.org). Laura Brockway can be reached at [laura-brockway@tmlt.org](mailto:laura-brockway@tmlt.org).*

## New information about medical record retention

In a recent review of medical record retention guidelines, it has come to our attention that the Texas State Board of Medical Examiners states "a licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of the date of last treatment by the physician." This language does not distinguish between record retention for deceased patients and record retention for living patients. Consequently, the medical records for adult patients should be retained for seven years from the date of last treatment and the records for a minor patient (a patient under the age of 18) should be kept for seven years or, until the patient is 21 years old, whichever is longer.