

# the Reporter

## A TMB complaint: one physician's perspective part 1

*Editor's note: Victoria Soto, JD is an Austin-based attorney who represents physicians before the Texas Medical Board (formerly the Texas State Board of Medical Examiners). Ms. Soto also advises health care professionals and medical groups in administrative, transactional, policy, and protocol matters related to their practices. In her article, readers will follow a fictitious physician, Dr. Goodnews, through the TMB complaint, investigation, and litigation process.*

I have been afforded two very interesting and important privileges in my career as an attorney. One was as a former staff attorney/prosecutor for the Texas Medical Board (TMB) and now, as a defense attorney representing physicians before the TMB. My role involves everything from helping them obtain a license to practice in Texas to defending them against actions by the TMB. To help readers understand what happens when a physician receives a complaint letter from the TMB, I will detail a year in the life of a composite physician. This physician is made up of physicians I have seen throughout my years as a staff attorney at the TMB, as well as some physicians I have defended before the Board. By following this fictional physician, readers will know what it's like — from the doctor's point of view— to be on the receiving end of a complaint before their licensing agency.

Dr. Leopold Goodnews is a surgeon who has been practicing medicine for the past 20 years. He has a thriving practice in a major city in Texas. His staff and his patients love him. He and his wife, a retired nurse, have four children: one daughter who attends school in Europe; one daughter who is a junior in high school; and two sons, one in medical school and the other a physician in residency. He belongs to the local medical society and the best golf club in the area.

Dr. Goodnews and his colleagues meet for lunch on Fridays. Every three months or so, the topic of conversation is the ever-popular *Medical Board Newsletter*. There are the usual "oohs" and "aahs" about who has been disciplined and why. Many times the doctors are appalled by an act committed by

their fellow doctor and are content with the Board's tenacity in disciplining that doctor. However, of late, they have become very concerned. Dr. Goodnews and his colleagues notice more disciplinary actions being taken against doctors for what they consider to be minor mistakes, such as failing to complete CME hours, failing to turn in medical records upon request in a timely fashion, and failing to furnish a new address on an application in a timely manner. These things seem simple to them and they understand the need to make sure that these things are done properly. But the idea that a doctor's name could appear in the newsletter — for the entire world to see — for something so minor is mortifying.

In the old days, the Board would have the doctor answer the charges and counsel them. It would not officially discipline them. Just the experience of having to answer to their peers was usually a very good deterrent and it avoided public embarrassment. This is no longer the case. Dr. Goodnews and his colleagues know that inadvertent mistakes occur on a daily basis and it is unthinkable that they could find their names in the newsletter. To Dr. Goodnews, looking in the newsletter is like an octogenarian looking in the obituaries hoping he won't find his own name. If he doesn't see his name, it is a good day. His friends laugh, pat each other on the back, and go their separate ways.

Dr. Goodnews gets into his vintage green and white 1956 GMC truck and drives home only to find his wife holding an envelope that says in the upper left-hand corner "Texas Medical Board." His face turns ashen. He has received the dreaded "nasty-gram," as this is lovingly called by other doctors who receive a complaint letter from the Board. The allegations on this particular day include falling below the standard of care, recurring liability claims, and unprofessional conduct.

*continued on page 2*

Dr. Goodnews, who has never had a complaint filed against him before, is shocked. Just receiving a letter from the TMB can be enough to destroy a physician's state of mind, especially if he sees himself as invincible, untouchable, or innocent. Several clients have told me that the entire experience is a nightmare from which they can't wake up until the TMB hears their side and judges them fairly. At that point, they can either be released from the charges or they can maintain their medical license under an agreed order that they can live with. Dr. Goodnews has found himself in a very tenuous position by receiving this letter. What he does next will set the stage for the entire process and the rest of his medical career.

The complaint letter that Dr. Goodnews received has given him 10 days to respond to the requested information. It says "A complaint has been filed against you that alleges that you have recurring liability claims and that you fallen below the standard of care regarding the following patients: Patient XR, YA, QU, and RF . . ." Unfortunately, by the time this letter was received, four days had passed. Dr. Goodnews now has only a short time to gather the medical records, write a narrative, review the narrative he wrote for the insurance company at the time of the claim, and think about whether to hire an attorney.

When he asked his colleagues if he needed to hire an attorney, he was wrongly advised that to hire an attorney at this stage would be a waste.\* Dr. Goodnews knew he was innocent of any wrongdoing, so why should he hire an attorney? He asked himself, "Don't only guilty people hire attorneys?" He had done nothing wrong.

According to Dr. Goodnews, in each of the liability claims against him, he had followed the standard of care. Each case had been dismissed at the civil court level. These claims included a worker's compensation case; a case with an elderly man who had recurring health problems unrelated to the surgical procedure that Dr. Goodnews performed; a young man who had severe arthritis from a very young age whose bones were brittle; and a man who was a malingerer caught on tape doing summersaults at a swimming party. To Dr. Goodnews, everything he did was textbook; he knew it, and as a result had nothing to worry about, right? Wrong! He would soon find out that not everything is as expected or as it should be.

What should Dr. Goodnews expect? For one thing, he should expect that it will take time for the TMB to process his complaint. Because it involved a standard of care complaint, his case had a greater chance of going to an investigation. Typically, the Board must give standard of care cases a certain amount of review to protect the public and to ensure that there is not a pattern of practice that makes this physician a danger to the public. Consequently, more than likely, a standard of care case will go to investigation and will be reviewed by one of the Board experts. This Board expert will then draft an opinion stating whether or not he or she found that the doctor violated Board rules. Once it is determined that enough evidence exists to suggest a violation in the standard of care, the doctor — in this case Dr. Goodnews — will receive a letter of notice of investigation. If Dr. Goodnews has not already hired an attorney to explain this investigation letter, receiving it may be alarming.

At this point, the TMB has assigned a case number and an investigator. An investigator's job is to collect information so that the Board expert can properly review the case and make a determination. Once the expert renders an opinion and returns this information to the investigator, the investigator then drafts a form. This form, along with the evidence, is reviewed by an internal review committee that determines if there is enough evidence to transfer the case to the litigation division.

Another friend of Dr. Goodnews has advised him to hire competent counsel as soon as possible. This attorney should be one that is experienced in working with the TMB. Dr. Goodnews hired an

attorney and responded to the initial complaint letter by drafting a response that said he would be happy to cooperate with the Board staff, but since the complaint letter and the investigation notice letter did not state specifically what the allegations were, he could only respond by sending the medical records of the patients cited in the complaint letter with no explanation. There are some attorneys who recommend that their clients not respond to the initial complaint letter. They feel that no matter what the doctor says, the case will go to an investigation anyway, so why waste an explanation at this stage of the game? In this instance, Dr. Goodnews' attorney recommended that he should, in fact, draft a narrative to answer the patient care allegations so that it would be available if the case goes to an investigation.

Once an investigation is opened, the investigator specifically asks for a narrative. If this narrative does not match the medical records, questions will be raised. After responding to the investigator's request, Dr. Goodnews asked who would be the Board expert reviewing his case. To his shock, he was told that the expert reviewer would be confidential. Though the list of Board panelists is public, each investigation file is confidential and the identities of the Board panelists reviewing that file are kept confidential to protect their identity and reduce the risk of liability to the individual panelist. The Board must have expert reviewers, and it has a great interest in protecting them. Dr. Goodnews understood this; however, he has a great interest in protecting his license from an unknown competitor. To level the playing field, the Board uses an expert who lives in another area and/or zip code than the physician under investigation. Later, upon review of the expert report, Dr. Goodnews will discuss the issue of confidentiality that poses a very interesting, yet simple, alternative to the system that would protect all parties to a greater degree.

In the meantime, Dr. Goodnews is still very apprehensive about the whole process and asks his attorney "What will happen to me?"

His attorney's answer was simple yet scary. She took a deep breath and replied: "If you are a doctor who has made a mistake and you're willing to acknowledge it and discover a way to avoid it in the future, then with the help of good counsel, you will survive the Board's disciplinary process. To phrase it in another way, if you are innocent, strong enough to cooperate with your attorney, and you prepare very well by having your own experts to prove your case, you will survive. More importantly, if you prepare for the actual appearance at the Informal Settlement Conference and you present yourself with respect for your profession, yourself, and the Board members, then you have a good chance of prevailing. On the other hand, if you are arrogant and angry and you feel that this is a monkey/kangaroo star chamber environment that you refuse to respect, then I would strongly advise you that you are placing your license at risk. It's about strategy, strength, and respect. Respect on all sides."

In the January-February 2006 issue of *the Reporter*, we will discuss the discoveries that Dr. Goodnews makes along the way to the litigation department. We will also see how he may have to accept seeing his name in the TMB newsletter.

\* Many medical liability insurance policies will provide coverage for legal expenses that occur if the policyholder faces a disciplinary proceeding. TMLT policies include a special endorsement called Medefense which provides legal expense reimbursement for disciplinary proceedings, including actions by the TMB. For more information or to find out if you qualify for reimbursement under Medefense, please call TMLT at 800-580-8658.

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# legislative update

## An overview of health care legislation from the 2005 session

*Editor's note: the following information regarding changes to health care law from the 79th Texas Legislative session was summarized and compiled by attorney Michael Crowe with the law firm of Brown McCarroll in Austin, Texas.*

### **Senate Bill 872 — specialty/niche hospitals**

Prohibits providers from recommending patients to a niche hospital when the provider (or immediate family) has financial interest in that hospital.

- Niche hospital is generally defined as surgical, cardiac, orthopedic, or women's hospital, but not psychiatric, rehab, drug/alcohol rehab, public, children's hospitals, or hospitals with fewer than 10 claims per bed per year.

- Financial interest does not include an interest in publicly available funds, such as mutual funds.

- Exceptions include situations where the physician discloses the interest to the patient in writing and informs the patient that alternative choices are available.

- The physician is also required to notify the Department of State Health Services (DSHS) of any ownership in niche hospitals on a form created by the Texas Medical Board (TMB).

### **Senate Bill 500 — health care discounts**

Allows health care providers to provide health care services at price discounts to uninsured patients.

### **Senate Bill 410 — prescription drugs**

Allows Texans to order prescription drug refills from up to 10 Canadian pharmacies approved by the State Board of Pharmacy.

- Authorizes the State Board of Pharmacy to inspect Canadian pharmacies that sell and ship prescription drugs to Texans upon passage of this inspection.

- Requires the Board to ensure that Canadian pharmacies meet Canadian, U.S., and Texas safety standards.

### **Senate Bill 492 — prescription drugs**

Allows for dispensing, sale, or distribution of compounded drugs to state-licensed physicians for in-house administration.

### **House Bill 836 — prescription drugs**

Requires a pharmacist, before making a generic substitution, to inform and allow patient to choose between generic and brand prescribed.

- Does not require notice for refills if the physician gives the patient informed choice and notifies pharmacy that they have provided the choice.

- Requires pharmacists to offer patients the option of paying for drugs at the lower price instead of paying amount of co-payment if the price of the drug is less than the co-payment amount.

### **House Bill 2765 — “legally authorized representative”**

Relates to the definition of a legally authorized representative under the Texas Hospital Licensing Law. Expands the definition to include:

- a person authorized to consent to medical treatment on behalf of the patient under the Consent to Medical Treatment Act;

- an heir of the patient, as defined by the Probate Code; and

- a person exercising power as an agent of the patient granted by a statutory durable power of attorney signed by the patient.

### **House Bill 805 — fingerprinting**

Allows EMS, ER medical, or admissions personnel to take a thumbprint to identify persons receiving emergency medical services who otherwise cannot be identified, if the person:

- has no personal identification at the time the care is administered;

- is unconscious;

- is transported across the Texas-Mexico border by ambulance or helicopter while receiving emergency pre-hospital care; and

- is delivered to a hospital that has digital fingerprinting capabilities.

### **Senate Bill 1330 — immunization of elderly persons**

Requires that any elderly person admitted to the hospital for more than 24 hours must be informed of the availability of pneumococcal and influenza vaccines and provided the vaccines before discharge if desired.

- Also requires that whenever feasible, physician offices and end-stage renal disease facilities must offer the same vaccines to elderly persons receiving care from them.

- When not feasible, information on availability must be offered.

### **House Bill 677 — emergency services after sexual assault**

Establishes minimum standards for a health care facility to meet when providing emergency services to sexual assault survivors.

- Allows DSHS to request that a hospital submit a plan for complying with minimum standards.

- Also requires DSHS to develop an information form for survivors detailing examination, treatment, and health risks after sexual assault.

### **Senate Bill 325 — facility treatment of patients**

Restricts physician and facility use of restraints and seclusion for the treatment of patients or residents in certain facilities.

- Requires the Health and Human Services Commission to adopt rules governing the use of restraint and seclusion techniques.

### **House Bill 224 — mental health treatment of minors**

Relates to the treatment of minors admitted for voluntary inpatient mental health services and discharge from that treatment for those persons.

- Provides that upon the written request for discharge from a minor admitted under 572.002(3)(B), mental health facilities shall “consult with” the patient's parents/guardians.

- If they object to the discharge in writing, the facility must continue the treatment of the patient as a voluntary patient.

- Provides that a facility may administer psychoactive medication to a patient who refuses the medication if: (1) the patient is younger than 18; (2) the patient was admitted under 572.002(3)(B); and (3) the parents/guardians consent.

- Does not apply to wards of the state.

*continued on page 15*

# TMLT Memorial Scholarship Winning Essays

In February, TMLT announced the creation of the TMLT Memorial Scholarships. In response, we received 30 applications from students at 7 Texas medical schools. The TMLT Board of Governors reviewed the submissions, and we are now proud to introduce the recipients of the 2005 TMLT Memorial Scholarships:

## Jesse Lee Even

To ensure patient safety and reduce the risk of medical malpractice lawsuits, physicians must first recognize that they will likely face legal liabilities if they don't take steps to safeguard their practice. Many of these liabilities can be minimized with easily implemented daily habits. This essay will explore a few straightforward preventative measures, and will focus on the need for greater physician/patient communication, the need for physician delegation of medical responsibility to the patient, the importance of physician utilization of technology to ensure patient safety, the need for physician-led communication between medical staff members, and finally the importance of continued medical education.

The simplest way physicians can promote patient safety and minimize medical malpractice lawsuits is to take the time to communicate with their patients. Taking a history and physical is one of the first lessons taught to students when they enter medical school. Medical schools teach physicians to ask the right questions, but also to listen to the patient's answers instead of reading down a laundry list of boilerplate questions. However, in the time-sensitive medical market of today, this art form has been long lost along with important medical information about the patient. This gap in the physician's knowledge of their patient could compromise the patient's safety and could ultimately result in a finding of negligence in a court of law. If physicians take the time to simply listen to and converse with their patients, many important aspects of the patient's medical history will be revealed, helping the physician determine the most appropriate care. In addition, when physicians effectively communicate with their patients, it shows the patient that their physician is truly concerned with their medical issue. This in turn creates an environment wherein the patient feels their physician is doing everything in their power to solve the patient's medical issue, thus promoting a relationship that is less likely to result in litigation.

Along with listening to their patient's complaints, physicians must also take the time to discuss their prescribed medical treatment with their patients in an understandable manner. All too many times physicians try to speed the patient through the office or send them off to surgery, but forget to empathize with and dispel any lingering fears of the patient. One way to solve this problem is for the physician to assume the patient has never heard of the prescribed procedure or treatment. The procedure or treatment should be explained to them on an introductory level, and then to be certain of their comprehension, the physician should ask the patient to recapitulate it to the physician. Finally, the physician must remember to ask their patients if they have any questions in a manner that invites inquiry. Physicians sometimes assume patients understand, when in reality many are confused but are too intimidated by medical terminology to ask questions. When a patient is unsure of what medical actions are being taken and why, they begin to develop feelings of distrust. This distrust could lead to legal action if a procedure or treatment doesn't turn out the way the patient expected.

Encouraging patients to feel responsible for their own care is another habit physicians can practice to ensure patient safety and reduce medical malpractice lawsuits. This is an important aspect of patient compliance, but it also fosters the notion that medical care is a team effort between the medical professionals and the patient. When a physician cultivates this type of environment the patient will feel more in control, and will therefore be more likely to take at least partial responsibility if a treatment doesn't work and less likely to sue.

**Danielle T. Burkett**, a third-year student at the UNT College of Osteopathic Medicine; **Jesse Lee Even**, a fourth-year student at the UT Medical School at Houston; **Jedidiah J. Grisel**, a fourth-year student at Texas A&M University College of Medicine; **Bradley Lega**, a fourth-year student at Baylor College of Medicine; **Rodolfo Jose Oviedo**, a third-year student at the UT Medical School at San Antonio; **Erin K. Shiner**, a third-year student at Texas Tech University School of Medicine; and **Rebecca Wald**, a third-year student at the UT Southwestern Medical School.

The \$5,000 scholarships were awarded to one student at each Texas medical school that participated in the competition. Recipients were chosen based on academic achievement, financial need, and essay. For the essay portion, students were asked to write 1000 words answering the question: "What can individual physicians do to ensure patient safety and minimize the risk of medical malpractice suits?"

The essays by Erin K. Shiner, Jesse Lee Even, and Jedidiah J. Grisel are printed in this issue of *the Reporter*. The essays by Danielle T. Burkett, Rodolfo Jose Oviedo, Bradley Lega, and Rebecca Wald were printed in the September-October 2005 issue of *the Reporter*.

Another important tool that should be utilized by physicians to ensure patient safety and minimize legal actions is the use of medical technology such as digital records and integrated pharmacologic programs. Digital medical records need to be made readily available to promote the sharing of patient information between physicians, which would increase the continuity of care. Imagine if a physician could pull up every visit their patient ever had in his or her lifetime and learn every medication they were ever prescribed. Not only would these records be extremely helpful in charting the care, but it would also increase the safety of the patient because the physician could access information the patient may have forgotten or never knew about. Such technology would also be helpful when prescribing medication. The technological accuracy would reduce the amount of incorrect doses and negative drug interactions caused by human error.

Physicians in the practice of surgery

have a particularly simple yet under-utilized method to increase patient safety. Because of the numerous lawsuits filed against surgeons who have performed operations on the wrong patients or amputated incorrect limbs, a system of identifying the patient and site of surgery has been implemented in most hospital settings. This consists of naming the patient and the procedure to be done verbally before the procedure begins. However, this procedure is often taken lightly, or not completed at all. In most cases, it is the nursing staff who have initiated these identification procedures. The patient is the physician's ultimate responsibility and physicians should take full command of these identification procedures to ensure the patient's safety and to prevent medical malpractice suits. This quick identification process is a valuable preventative measure that must be utilized.

The final way physicians can ensure patient safety and minimize the risk of medical malpractice suits is through continued medical education. Physicians have an obligation to their profession, and especially to their patients, to be up-to-date with the most accurate medical information available. It should be the goal of every physician to read an article daily that will further their medical knowledge. This simple task will not only convey to colleagues and patients that the physician takes his or her profession and patient care seriously, but it also serves to prevent medical mistakes.

There are many avenues that physicians can take in daily practice to ensure patient safety. Increasing physician/patient communication, physician delegation of medical responsibility to the patient, physician utilization of technology, physician-led communication between medical staff, and continued medical education are only a few ways patient safety can be protected. And when physicians position the safety of the patient as their top priority, the number of frivolous lawsuits will decline automatically.

## By Jedidiah Grisel

**T**he reasons why patients bring lawsuits against providers are as variegated as patients themselves. However, underlying almost all litigation is a sense of distrust; for some reason the patient feels that the doctor's actions are inconsistent with their best interest. Since litigation is often the result of a breakdown in trust, physicians can prevent and reduce unnecessary lawsuits by strengthening the doctor-patient relationship. Researchers at the Mays Business School at Texas A&M University and Scott & White have shown that physician behaviors are the most powerful predictors of patient commitment. Patients who trust their doctor and are committed to the relationship are more likely to forgive mistakes, accept poor outcomes and seek understanding before turning to legal options.

There are many things that physicians can do to strengthen the doctor-patient relationship. Three important examples are providing patient-centered access, cultivating a spirit of transparency and implementing evidence-based guidelines. In addition to strengthening relationships, these strategies also ensure that patients receive care that is safe, effective, patient-centered, timely, efficient and equitable.

Every patient has expectations about when and how they can access their doctor. Trust is diminished when a patient's important health problems (whether perceived or real) are put off for weeks because the doctor's schedule is packed. The message sent is that the patient's problem is not important or, worse, that the doctor just does not care. Careful scheduling techniques as well as providing a variety of access options can remedy this problem. Many practices implement "open-access" scheduling where a certain percentage of each day is left open for office visits. When used appropriately, this system can help meet the needs of more patients without leaving precious office-visit slots unfilled. Additionally, many patients do not need or want an office visit for every medical problem. Oftentimes, a variety of nontraditional access options may more appropriately meet these patients' needs. Telephone and email consultations are becoming more accepted as legitimate means of communicating with patients. Many clinical situations, such as emergencies or new patient visits, do not lend themselves to these types of communication. However, judicious use of telephone and email can save patients a trip to the doctor's office and can also open up more clinic time for others. Patients who obtain access to health care when and how they want are more likely to feel satisfied with their doctor and trust that their care is appropriate.

Cultivating a spirit of transparency is another way physicians can strengthen trust with their patients. This standard of honesty should permeate every aspect of the physician's practice, including relationships between staff, nurses, doctors, and patients. The threat of legal involvement tempts many providers to hide mistakes. Intuitively, one may think that full disclosure of all wrongdoing may leave a physician vulnerable to increased litigation. There are several reasons, however, why

maintaining a policy of complete transparency is the better choice, even in a litigious society. Unless mistakes are reviewed and examined, there is no way to prevent these errors from occurring again. Doctors can promote a spirit of non-punitive error reporting in their practice by admitting to their own errors and praising others for doing the same. The ultimate example is for doctors to fully disclose medical errors to patients without reservation. Most patients are willing to forgive even the most grievous errors, but they are not willing to overlook dishonesty. Nothing destroys trust more than dishonesty and secrecy in the doctor-patient relationship. Therefore, patients should be given complete access to their record, without fees or hassles, and they must always feel that the doctor is being open and candid. In cases of legitimate breaches in the standard of care, doctors should provide restitution. This strategy will not eliminate all lawsuits, but it will strengthen trust with patients, open lines of communication before litigation is sought, and provide a means to examine errors.

Finally, when patients receive clear, consistent messages from multiple health care sources, their trust in their care is increased. Medicine is often complicated and confusing, and when patients receive information that is conflicting, they become more confused. As a profession, physician and specialty associations should (and many do) make it a priority to establish evidence-based guidelines that reflect the most current research. By implementing such guidelines, physicians can be confident that their recommendations are in the best interest of the patient according to the current state of scientific knowledge. This principle has been applied in other industries successfully. For example, airline pilots are governed by strict guidelines to ensure a certain level of performance during flight. Customers can expect the same degree of safety regardless of who is flying the plane, so long as a licensed pilot is in the cockpit. Similarly, patients should be able to depend on health care that is up-to-date and accurate, no matter who is providing their care.

The thought of influencing medical litigation can seem daunting for physicians when one considers the size and complexity of the issue. However, interacting with patients is something that every doctor does every day. By using these interactions to strengthen trust, physicians can create bonds with patients that become safeguards against litigation in the face of unfortunate events. Despite the complexities of modern medicine, we still find ourselves in a profession that requires not only intellectual knowledge, but emotional and interpersonal skill as well. The words of Sir William Osler ring true today when he said "Our fellow creatures cannot be dealt with as a man deals in corn and coal; 'the human heart by which we live' must control our professional relations."

In the United States, medical errors are estimated to lead to nearly 100,000 preventable patient deaths and to cost \$9 billion in injuries annually<sup>1</sup>. In the midst of this dilemma, the U.S. is also experiencing a medical liability insurance crisis. A report from the General Accounting Office designated losses incurred from malpractice claims as the primary contributor to increased medical liability insurance premiums.<sup>2</sup> A recent survey of physicians practicing in rural Florida uncovered that the mean increase in their insurance premiums was 93.5% from the previous year.<sup>3</sup> Thus, there is an urgent need for improvement in the health care system that would lead to increased patient safety and reduce the risk of malpractice.

To address the role that the physician can have in improving patient safety, I have developed a model called RAPPOR (Read, Advocate change, Patient communication, Participate in research, Open collaborations, Report it, Technology). This essay will address each of these areas and how the utilization of this system can improve patient safety at the level of the physician.

**Read.** An important task of every physician is to stay abreast of current scientific and medical literature in his/her area of medicine. Besides subscription to medical journals, physicians can browse current literature easily through specialized search engines (i.e. PubMed, MDConsult). Furthermore, online subscription to news alerts from various medical networks can keep the physician current on changing medicine.

**Advocate change.** Changes at the hospital, state and national levels are quite necessary for improving patient safety. Through membership in medical organizations (i.e. TMA, AMA), caregivers can be aware of the issues under review by lawmakers. The individual physician should make his/her voice heard by writing letters to state and national representatives on issues such as regulation and health care reform. In addition, a physician can participate in change within a health care organization by sitting on planning committees or assisting in coordinating change as his/her time allows.

**Patient communication.** Good rapport with patients can promote patient safety and reduce malpractice, and rapport is the very root of this model. Patients who are at ease with their physicians are more likely to relay important information to their doctors. By educating patients on the importance of taking their prescribed drugs and going in for clinical tests, it is more likely that the patients will be compliant. Furthermore, understanding the financial capabilities of patients will enable the physician to prescribe accordingly and to increase compliance as well. Because of time constraints, it is very tempting for caregivers to manage several different tasks at a time, but multitasking will inevitably lead to errors and should be avoided. The University of Colorado School of Medicine utilizes a communication skills technique that is referred to as Invite, Listen, and Summarize. This method creates rapport, collects good data, and improves compliance during the medical interview through active listening in which the physician makes eye contact, avoids distractions during the interview, and summarizes the patient's words to allow for corrections and elaborations.<sup>4</sup>

**Participate in research.** Health services research is a vital tool for improving the health care system. It is through research that problem areas can be identified and corrected. If an opportunity arises for a physician to participate in a research survey/study on patient safety or malpractice issues, the physician should definitely take part.

**Open collaborations.** One of the most powerful patient safety tools at the hands of every physician is the ability to form strong collaborations with other health care workers, including nurses and providers of end-of-life care. During an invitational conference in 2001 sponsored by the Agency for Healthcare Research and Quality and the ABIM Foundation, the point was made that the focus of health care needs to shift from acute to chronic care, which bears complex morbidities, and so a team approach to treating the patient will need to be well established.<sup>5</sup> Referrals and collaborations formed between physicians and other health care workers are a necessity for optimal patient care.

**Report it.** One strategy to reduce medical errors is the use of a reporting system to identify and learn from errors made by caregivers. Reporting of medical errors is concerning, however, because of the potential consequences of reporting, including

greater frequency of lawsuits, negative repercussions on the reporting practitioners, and frightening the public unnecessarily.<sup>6</sup> Realistically, though, errors tend to recur in a pattern in which a set of circumstances can provoke similar mishaps, thus it is imperative that practitioners report errors.<sup>7</sup> Furthermore, physicians should report near-misses (events that could have had adverse consequences but did not) because the benefits of these data could lead to discoveries of procedures with imminent risk and enable focused improvements in training, organization, management of work, and the design of systems without carrying the liability of full-fledged medical errors.<sup>1</sup>

**Technology.** Electronic patient management tools can reduce errors by alerting physicians of abnormal test results or non-compliance with tests in addition to freeing up some valuable time for physicians.<sup>8</sup> Physicians should learn how to use the electronic tools available at their particular institution. Also, handheld devices are a valuable and portable tool that can store a number of medical software programs to assist the physician in providing top quality care to patients in order to reduce the frequency of medical errors.

Overall, the RAPPOR model was designed to address the need for improvement in patient safety and reduction of medical malpractice risk. There is a critical need for intervention in health care systems at a national, state, and institutional levels; however, the physician also has a very active role in improving patient safety. The items outlined in this model are all areas in which the individual physician can be active.

## References

1. Barach P, Small SD. Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. *BMJ*. 2000.320(7237): 759-63.
2. USGA. Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. GAO Report-03-702. June 2003.
3. Brooks RG, et al. Impact of the medical professional liability insurance crisis on access to care in Florida. *Arch Intern Med*. 2004. 164(20): 2217-22.
4. Boyle D, Dwinnell B, Platt F. Invite, listen, and summarize: a patient-centered communication technique. *Acad Med*. 2005. 80(1): 29-32.
5. Goode LD, et al. When is "good enough"? The role and responsibility of physicians to improve patient safety. *Acad Med*. 2002. 77(10): 947-52.
6. Weissman JS, et al. Error reporting and disclosure systems: views from hospital leaders. *JAMA*. 2005. 293(11): 1359-66.
7. Reason J. Human error: models and management. *BMJ*. 2000. 302(7237): 768-70.
8. Poon EG, et al. "I wish I had seen this test result earlier!": Dissatisfaction with test result management systems in primary care. *Arch Intern Med*. 2004. 164(20): 2223-8.

# ethics exchange

## Economic choices and moral dilemmas

compiled and edited by Howard Marcus, MD

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

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

A 65-year-old woman came to her primary care physician with new onset hypertension discovered during a dental examination. For many years this patient had been treated by the same physician at an urgent care clinic for routine physicals and minor illnesses. When the patient requested an appointment to see this physician for evaluation and treatment of hypertension, the clinic receptionist informed her that the practice did not accept Medicare patients. The patient was told that she would have to find care elsewhere. She was not offered an appointment and she was given no assistance in finding a new physician.

### **By Russell Hoverman, MD, PhD, hematology/oncology, medical ethics, in Austin**

It is worthwhile to begin with the foundations of modern medicine, that of the Guild of Hippocrates in ancient Greece. Around 400 BC, the time the Guild was founded, medicine was "the most noble of all the arts, yet...it had fallen into the least repute of them all." There were no penalties for bad outcomes and anyone could claim the craft of medicine. The self-proclaimed practitioners could treat whomever they pleased and were allowed to levy fees for their services. It is in this environment that the members of the Hippocratic Guild distinguished themselves by their now familiar code.

The teachings of Hippocrates and the rise of the American Medical Association and other medical societies clarified standards of

practice in the mid-1800s, another chaotic era in medicine. At that time "no one knew who or what physicians were, except as they claimed... Some unscrupulous horse doctor would set up his sign... and draw his lance on you." It was within this context that the AMA was formed with one of its first duties the publication of a Code of Ethics (1847). As a consequence of the teachings of Hippocrates and the codes of ethics of modern medical societies and associations, physicians have important guidelines to form their decisions.

Now, as in ancient Greece, physicians operate in a free market. A physician is not obligated to lose income to practice his or her profession. However, the market, although free, is not perfect. A perfect market is one in which all transactions are transparent; that is, both the buyer and seller are fully informed, and goods and services are traded at fair prices. In an imperfect market, such as medical care, one party has access to a very complex and specialized knowledge base. It is very difficult for a consumer (patient) to determine the fair market value of services delivered by professionals. It is necessary for professional societies to characterize these goods and services and contribute to a determination of fair market value. The rise of third party payers, such as Medicare, who largely determine the value of physician's services, further complicates the medical marketplace.

This case involves three issues. 1) Once a physician-patient relationship is established, can a physician terminate that relationship based on economic criteria? 2) What is the obligation of the physician in the termination of that relationship? 3) Can a physician exclude entire categories of patients from a practice on economic criteria alone?

The answer to the first question is straightforward. In a free market, either the patient or physician can terminate the relationship based on economic criteria. However, regarding the second issue, the physician has an obligation to continue necessary care for established patients until a reasonable alternative can be found. The answer to the third question implies an obligation to inform the patient of the potential for termination of the

doctor-patient relationship on economic grounds before initiating the doctor-patient relationship in the first place. If it is known that the relationship will likely be terminated at some future date based on economic criteria, the patient should be informed of this at the onset. In this example, the urgent care clinic had an obligation to clearly inform potential patients that they do not accept Medicare, and that once patients reach age 65 they would need to find medical care elsewhere. The practice should not have waited until the patient had actually reached age 65 to inform her of the policy and to terminate the relationship without adequate warning.

### **By Celeste Lira, RN, JD, health law attorney and partner with the law firm of Brin & Brin, PC, in San Antonio**

"...The secret of the care of the patient is in caring for the patient. Does that sound too noble and good in these changing times?"<sup>1</sup>

By history, tradition, and professional oath, physicians have a moral obligation to provide care for ill persons. Although this obligation is collective, each individual physician is obliged to do his or her fair share to ensure that all ill persons receive treatment. A long-standing school of thought has held that a physician should not discriminate against a class or category of patients.<sup>2</sup> Ethical tensions occur when physicians are faced with increased numbers of patients who cannot pay for medical services or whose employers have changed or discontinued health insurance coverage.

This case addresses whether physicians can accept some people as patients and deny others. The AMA has consistently held that the physician's right to choose patients is the counterpart of a patient's right to choose a doctor. In its ethical policy statement, the Texas Medical Association notes that a physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services. Other physician groups echo

*continued on page 16*



## *An issue of patient safety*

# Nosocomial infection

### Objectives

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

1. Identify the four types of nosocomial infections that account for the majority of all nosocomial infections.
2. Discuss the impact of nosocomial infections in terms of incidence and associated costs of patient care.
3. List allegations prevalent in litigation involving nosocomial infections.
4. Evaluate his or her practice for adherence to strict infection control standards.

### Course author

Laura Brockway is a senior communications and advertising representative at TMLT.

### Disclosure

Laura Brockway has no commercial affiliations/interests to disclose related to this activity.

### Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

### CME credit statement

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 November 28, 2005, and expires on December 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

Nosocomial infections (often referred to as health care-associated infections) are the most common complication affecting hospitalized patients, and they affect all patient populations. Young, old, sick, healthy, surgical, medical — all are at risk for acquiring an infection while admitted to a hospital. As nearly 70% of nosocomial infections are now resistant to at least one antibiotic,<sup>1</sup> and with reports of patients infected with vancomycin-resistant *Staphylococcus aureus* in the U.S., “the specter of hospital epidemics of an untreatable infection is daunting.”<sup>2</sup>

This CME article will review four types of nosocomial infection, CDC surveillance efforts, recent legislation calling for mandatory reporting of infection rates, liability for nosocomial infection, and prevention and risk management strategies.

Though this article will use the term nosocomial (meaning hospital-acquired), these infections cause considerable complications both in and out of the hospital. As John Boyce, MD, co-author of CDC’s infection control guidelines told *American Medical News*, “when patients who have been in and out of hospitals come into the office, they continue to carry resistant bacteria on their skin, such as vancomycin-resistant enterococci or methicillin-resistant *Staphylococcus aureus*.”<sup>3</sup> Therefore, published infection control guidelines and risk management considerations are applicable to all health care providers.

## The most common complication

According to the CDC, nosocomial infections affect 2 million patients per year and result in 90,000 deaths per year. Although the number of admissions to hospitals and the average length of stay decreased from 1975 to 1995, the incidence of nosocomial infections increased from 7.2 to 9.8 per 1000 patient-days. Costs associated with nosocomial infections add an estimated \$4.5 to \$5.7 billion per year to the cost of patient care.<sup>1</sup>

“One-fourth of nosocomial infections involve patients in intensive care units, and nearly 70 percent are due to microorganisms that are resistant to one or more antibiotics.”<sup>1</sup> Four types of infection account for more than 80 percent of all nosocomial infections: urinary tract infection, surgical site infection, health care-associated pneumonia, and catheter-related bloodstream infections.

## Urinary tract infections

Urinary tract infections (UTIs) are the most frequent type of nosocomial infection, accounting for 35% of these infections. UTIs carry the lowest cost and lowest mortality.<sup>1</sup> “More than 80 percent of UTIs are associated with an indwelling urinary catheter and risk

increases with duration of catheterization.”<sup>4</sup>

Many guidelines and strategies have been published to help prevent UTIs and include assessing the need for catheterization, the use of aseptic procedures for catheter insertion, and the appropriate time to initiate antibiotic therapy when symptoms of infection appear.<sup>4</sup>

## Surgical site infections

Surgical site infections (SSIs) are the second most common nosocomial infection (about 20%), and the third in cost. It is estimated that SSIs develop in 2% to 5% of patients undergoing clean extra-abdominal operations and up to 20% of patients undergoing intra-abdominal operations. According to the CDC, 500,000 SSIs occur annually in the U.S.<sup>5</sup>

Important factors in the prevention of SSIs are: the general health of the patient; meticulous operative techniques; and timely administration of preoperative antibiotics.<sup>6</sup>

Several guidelines for the prevention of surgical infection have been published. In 2003, authors from the groups publishing these guidelines met with representatives from the CDC’s Surgical Infection Prevention Project. The consensus positions from this work group include:

- Infusion of the first antimicrobial dose should begin within 60 minutes before surgical incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 minutes before incision to prevent antibiotic-associated reactions.
- Prophylactic antimicrobials should be discontinued within 24 hours after the end of surgery. One guideline exception is for cardiothoracic surgery, as recommended by the American Society of Health-System Pharmacists, which recommends continuing prophylaxis for up to 72 hours after the surgery.<sup>5</sup>

“Despite the conclusive data supporting the efficacy of these recommendations, antimicrobial prophylaxis is often given incorrectly.” The most common errors are administration too early or too late and continued prophylaxis beyond the first 24 hours.<sup>6</sup> A list of recommended antimicrobials for specific procedures is available at [www.guideline.gov](http://www.guideline.gov).

Another way to reduce surgical infections involves surveillance and reporting of SSIs to surgeons. Two studies published in the *Archives of Surgery* and one study published in *Seminars in Infection Control* found that active surveillance of SSIs with confidential feedback of the data to surgeons consistently resulted in a decline in infection rates.<sup>7-9</sup> “We know that informing surgeons of their

wound-infection rates can lead to reductions in those rates, presumably by reinforcing the use of sensible interventions (e.g., limiting the amount of movement in and out of operating rooms in order to lower bacterial loads).”<sup>10</sup>

## Health care-associated pneumonia

Though health care-associated pneumonia (HCAP) is less common, accounting for 15% of nosocomial infections, it is associated with much higher mortality rates and health care costs.<sup>1</sup>

Hospital-acquired pneumonia (HAP) accounts for up to 25% of all ICU infections. In ICU patients, nearly 90% of episodes of pneumonia occur during mechanical ventilation and the incidence increases with the duration of ventilation. The risk of ventilator-associated pneumonia (VAP) is highest early in the hospital stay. “Because most mechanical ventilation is short term, approximately half of all episodes of VAP occur within the first 4 days of mechanical ventilation. The intubation process itself contributes to the risk of infection, and when patients with acute respiratory failure are managed with noninvasive ventilation, nosocomial pneumonia is less common.”<sup>11</sup>

VAP is most commonly caused by infection with one or more bacterial pathogens, many that are multi-drug resistant (MDR). “Infections due to gram-positive cocci, such as *Staphylococcus aureus*, particularly methicillin resistant *S. aureus* (MRSA), have been rapidly emerging in the United States. Pneumonia due to *S. aureus* is more common in patients with diabetes mellitus, head trauma, and those hospitalized in ICUs.”<sup>11</sup>

The American Thoracic Society and the Infectious Diseases Society of America (IDSA) have identified several modifiable risk factors that contribute to the development of HCAP, including intubation and mechanical ventilation, supine patient positioning, and enteral nutrition.<sup>11</sup>

Guidelines for the prevention of nosocomial pneumonia have been developed by the CDC and are available at [www.guideline.gov](http://www.guideline.gov). Effective prevention strategies include: strict infection control; alcohol-based hand disinfection; use of surveillance and reporting of local MDR pathogens; monitoring and early removal of invasive devices; and programs to modify antibiotic-prescribing practices.<sup>12</sup>

## Catheter-related bloodstream infections

Catheter-related bloodstream infections account for 15 percent of nosocomial infections, but lead to higher mortality rates and health care costs. These infections are also the most rapidly increasing in frequency

with a current incidence nearly three times the incidence in 1975.<sup>1</sup>

Research has shown several factors influence the risk for a catheter-related bloodstream infection. These include catheter site location and duration, errors in catheter insertion and management, and low nurse-to-patient ratio.<sup>13</sup>

The CDC, the IDSA, and a working group of members from a variety of medical disciplines have developed guidelines for the prevention of catheter-associated infections. "Strict adherence to hand hygiene recommendations and the use of aseptic techniques remain the most important measures for the prevention of catheter-associated infections."<sup>13</sup>

Other prevention strategies include:

- "choosing appropriate sites for catheter insertion;
- using the appropriate type of catheter material;
- using barrier precautions during insertion;
- changing catheter administration sets at appropriate intervals;
- ensuring proper catheter-site care; and
- ensuring removal of catheters when no longer essential."<sup>13</sup>

#### CDC surveillance

In the United States, nosocomial infection rates are measured by the CDC's National Nosocomial Infections Surveillance System (NNIS). The NNIS receives monthly reports of nosocomial infections from 315 hospitals (a non-random sample of U.S. hospitals, all with at least 100 beds and nearly 60% academic medical centers). These reports are confidential and participation in the NNIS is voluntary. The data from these reports have established benchmarks for hospital infection rates through the use of standardized case definitions and data-collection methods.<sup>4</sup>

"In theory, hospitals whose infection rates compare poorly with NNIS benchmarks should be motivated to identify preventable causes of infection and target interventions to prevent systematic errors, unless other explanations for the increased rate are evident."<sup>4</sup>

Analysis of NNIS data also helps reveal changes in patterns of incidence, distribution, antibiotic resistance, sites of infection, outcomes, and risk factors. The NNIS, which was established in 1970, is the only national source of systematically gathered data on hospital infections. "The 30% to 40% decline in infection rates reported by NNIS System hospitals in the past decade suggests that this monitoring and benchmarking approach can be effective in promoting patient safety and preventing some medical errors."<sup>4</sup>

The most recent NNIS report, a summary

of data collected from January 1992 through June 2004, is available at [www.cdc.gov/ncidod/hip/SURVEILL/NNIS.HTM](http://www.cdc.gov/ncidod/hip/SURVEILL/NNIS.HTM).

#### Mandatory reporting

The voluntary and confidential nature of the NNIS system are important factors in its success.<sup>1</sup> However, others are calling for mandatory public disclosure of nosocomial infection rates.

The belief that hospitals reporting lower infection rates are safer and that informed consumers will obtain safer care has driven the Consumers Union and other consumer groups to call for laws requiring hospitals to disclose infection rates. A Consumers Union representative told the *Houston Chronicle*, "There are always going to be some infections. But we believe that the vast majority are preventable and could be avoided if hospitals followed set procedures. So making them track and making them take it more seriously would help."<sup>14</sup>

In less than one year, 38 states introduced legislation and seven states (Florida, Illinois, Missouri, Nevada, New York, Pennsylvania, and Florida) passed laws requiring disclosure of infection rates to the state, and in most cases, to the public.<sup>10</sup> In 2005, the Texas Legislature passed Senate Bill 872, which created a 14-member advisory panel to study mandatory reporting of nosocomial infection. The panel will report to the legislature in 2006.<sup>14</sup>

As consumers demand transparency in reporting infection rates, many wonder if they will know how to interpret the data when it is released? Research demonstrates the difficulty in comparing infection rates among hospitals due to essential differences in patient populations. When infection rates are not "risk adjusted" for patient populations, smaller hospitals have lower prevalence rates compared to intermediate or large hospitals (6.1 versus 10 and 10.9 respectively). However, when infection rates were "risk adjusted" in a multivariate analysis, hospital size was not a significant factor.<sup>15</sup>

"This highlights the fact that comparisons among hospitals are only valid when nosocomial infection rates are adjusted to account for the overall health of the patient, and the specific surgical factors, as in the CDC's National Nosocomial Infection Surveillance System (NNIS)"<sup>15</sup>

In an opinion piece published in the *New England Journal of Medicine*,<sup>10</sup> the authors wrote that public reporting of infection rates was inevitable and urged hospital officials to work with consumer groups to develop fair public reporting systems in every state. "For states that have passed laws requiring public reporting, we suggest measuring rates

that can be compared meaningfully, that should be tracked anyway, and whose reporting is most likely to lead to improved care. Such process measures include assessments of the timely administration of peri-operative antibiotic prophylaxis, vascular-catheter insertion practices and hand hygiene."

"Most important, states must work with experts in health care communications and consumer reporting to define the sorts of rates that will tell patients what they need to know."<sup>10</sup>

#### Liability issues

As the most common complication suffered by hospitalized patients, nosocomial infections are also a significant source of health care litigation.<sup>16</sup> Typical allegations in these suits include:

- failure to timely diagnose the nosocomial infection;
- failure to timely initiate treatment for the infection;
- failure to deliver appropriate therapy for the infection;
- failure to institute appropriate isolation measures;
- inadequate prophylaxis;
- failure to inform the patient of the infection;
- infection due to faulty equipment; and
- infection due to faulty handling of equipment.<sup>17</sup>

According to the *Journal of Legal Medicine*, courts and juries are hesitant to find hospitals liable for nosocomial infections. "The rationale for the judicial reluctance is twofold — some nosocomial infections cannot be eradicated despite the greatest care, and plaintiffs have difficulty identifying the specific disease-causing pathogen. Hence, a causation issue exists. Therefore, if a plaintiff cannot point to a traumatic or obvious event, difficulties in proving proximate causation lead to verdicts in favor of the defendant hospital."<sup>18</sup>

To establish liability for nosocomial infections, the plaintiff must prove five essential elements. These elements are: "(1) an infectious disease caused the injury or death; (2) the patient contracted the infection while they were in the hospital; (3) the infection was contracted from a source within the hospital; (4) health care professionals were aware or should have been aware of the infectious source within the hospital; and (5) health care professionals negligently exposed the patient to the infection."<sup>19</sup>

While it is difficult to establish proximate cause in nosocomial infection cases, hospitals have been found liable based on obvious

deviations from the standard of care or a traumatic event.

A Washington hospital was successfully sued when a surgical patient later contracted an *S. aureus* infection from his hospital roommate. The roommate tested positive for the same infection before being transferred to an isolation ward. The hospital had rules requiring the isolation of all patients with known Staph infection, and health care workers were instructed to comply with sterile techniques when treating these patients. The evidence demonstrated that nurses treated both the patient and the roommate without complying with sterilization techniques, including handwashing.<sup>18</sup>

In another case resulting in a jury verdict against a hospital, the plaintiff underwent surgery to implant a metal ball into his fractured right hip. During postoperative physical therapy, the patient fell. His surgical wound reopened and an unsterilized bath towel was placed on the open wound to stop the bleeding. A nurse closed the wound with surgical tape and did not examine or clean the wound. The plaintiff's expert testified that the site of the patient's Staph infection was the reopened wound. "The Arkansas court affirmed the verdict in favor of the plaintiff, concluding there was sufficient evidence to find the Staph infection was caused by the incident during physical therapy."<sup>18</sup>

### Prevention of nosocomial infections — hand hygiene

While there are many ways to reduce nosocomial infection rates (including having appropriate hospital staff ratios and an effective surveillance system), hand hygiene is recognized as the most important activity to prevent and reduce nosocomial infections. "The importance of this simple procedure is not sufficiently recognised by health-care workers (HCWs), and poor compliance has been documented repeatedly."<sup>20</sup>

In the United States, hand hygiene rates average 40% to 60%.<sup>21</sup> Risk factors for poor adherence to hand hygiene have been extensively studied,<sup>22</sup> and the most important factors for noncompliance were being a physician and a high demand for handwashing.<sup>23</sup> "That physicians are poor handwashers is well known, although the reasons for this are unknown."<sup>24</sup>

The time required to complete handwashing is considerable. "High workload is a serious difficulty, especially in intensive-care units: in an hour of care there are as many as 40 opportunities to wash hands. It takes at least one minute to wash hands (going to the sink, washing, returning to the patient) and in such a context 'no time

for handwashing' is not an excuse but a reality: compliance would mean one-fifth of nursing time would be spent on handwashing."<sup>24</sup>

To solve this common objection to handwashing, researchers in infection control began studying the use of alcohol-based hand rubs that take 20 seconds to use and can be used at the patient's bedside. The effectiveness of alcohol-based hand rubs in disinfecting hands has been well documented.<sup>21</sup>

In a study published in *The Lancet*, Pittet and colleagues demonstrated the effectiveness of a long term, hospital-wide program to promote hand hygiene at the University of Geneva hospital. The hand-hygiene campaign specifically emphasized the practice of bedside, alcohol-based hand disinfection. Overall hand hygiene compliance improved significantly from 47.6% in 1994 to 66.2% in 1997. The greatest compliance increases were achieved by nurses and nursing assistants with 70% to 80% compliance. Physician compliance remained about 30% and showed no significant increase over time. The prevalence of nosocomial infections decreased during the campaign from 16.9% in 1994 to 9.9% in 1998, and the incidence of MRSA decreased from 2.16 to 0.93 episodes per 10,000 patient days.<sup>20</sup>

While Pittet and colleagues demonstrated that the use of alcohol-based hand rubs can decrease nosocomial infections, the study also reinforced the characterization of physicians as noncompliers. "At our hospital, physician behavior did not improve substantially despite a hospital-wide hand hygiene promotion campaign that had a positive and marked effect on adherence among all other health care workers."<sup>22</sup>

To understand the continued noncompliance rate among physicians, Pittet and colleagues conducted an observational study of hand hygiene practices and surveyed the beliefs and perceptions of the physicians they observed.<sup>22</sup> In this study, hand hygiene rates among physicians averaged 61% when they thought they were being observed; and 44% when physicians did not think they were being observed. Factors independently associated with compliance included internal medicine specialty, awareness of being observed, perception of being a role model for colleagues, and positive attitudes toward hand hygiene after patient contact.<sup>22</sup>

"Somewhat surprisingly, two thirds of respondents perceived hand hygiene as a difficult task, despite the ease of using sinkless hand-rub solutions."<sup>25</sup>

"After more than 150 years of prodding, cajoling, educating, observing, and surveying physicians, hand hygiene rates remain

disgracefully low. Moreover, physicians in at least one large survey perceive hand hygiene as a difficult task. The age of reason is over. Hand hygiene and use of alcohol-based hand rub solutions must become a ritual, automatic behavior. We must bind alcohol hand-rub solution dispensers on every doorpost in every health care facility. Physicians must use the products as a matter of ritual on entering and leaving every patient's room."<sup>25</sup>

### CDC hand hygiene guidelines

In 2002, the CDC released updated hand hygiene guidelines as part of an overall strategy to reduce infections in health care settings. Highlights from the recommendations include:

- When hands are visibly dirty, soiled, or contaminated, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.
- If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in the following situations. (Alternatively, wash hands with an antimicrobial soap and water in the following situations.)
  - Decontaminate hands before having direct contact with patients and after contact with a patient's intact skin.
  - Decontaminate hands after contact with bodily fluids or excretions, mucous membranes, non-intact skin, and wound dressings.
  - Decontaminate hands if moving from contaminated-body site to a clean-body site.
  - Decontaminate hands after contact with inanimate objects in the immediate vicinity of the patient.
  - Decontaminate hands after removing gloves.
  - Decontaminate hands before applying sterile gloves when inserting a central intravascular catheter.
  - Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.<sup>21</sup>

The full list of CDC recommendations, along with a comprehensive literature review of the scientific data regarding hand hygiene, is available at [www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm).

### JCAHO

Following the release of the CDC guidelines, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) added Goal 7: "Reduce the risk of

health care-associated infections” to its National Patient Safety Goals. The requirements for this goal call for all accredited organizations to be in compliance with the CDC’s hand-washing guidelines, and all unanticipated deaths or major permanent loss of function associated with nosocomial infections to be managed as sentinel events. JCAHO also requires that hospitals have a comprehensive, organization-wide program for the surveillance, prevention, and control of infection.<sup>26</sup>

During a speech at the Infection Control Conference in 2003, JCAHO President Dennis S. O’Leary said “These standards put leaders of health care organizations on notice that they are responsible for the effectiveness of their infection control programs. There is now even a separate standard which requires the allocation of sufficient resources to support the infection control program. We will be surveying this requirement closely.”<sup>27</sup>

### Risk management considerations

While many of the following recommendations are more applicable to inpatient hospital care, all health care providers can benefit when these are adapted for use in an office setting.

- Comply with CDC guidelines for hand hygiene. In your office, develop written protocols for pre- and post-patient care hand-washing or decontamination.

- Comply with your facility’s infection control guidelines.

- Prescribe antibiotics appropriately, following published guidelines.

- Vaccinations for health care workers — the CDC identifies health care professionals, as well as the sick and elderly, as those who should receive priority treatment for immunizations. Infection control experts would like to see more widespread vaccination of health care workers against hepatitis B, pneumococcal disease, and influenza.<sup>28</sup>

- Separating well and sick patients — another effective way to decrease the risk of infection in the office is to separate staff and other patients from those patients carrying infection. “Pediatricians have long practiced one method for keeping well patients from being exposed to sick ones — separate waiting rooms, one for well children and one for sick children.” If the waiting rooms cannot be separated, an infectious patient could be shown into an exam room to wait instead of in the general waiting area.

- While having separate waiting areas is not always possible, some practices separate the well and sick patients by scheduling. Morning hours are reserved for walk-in sick patients or for sick-patient appointments and

afternoon hours are reserved for well checks or follow-up appointments.

- Practices with play areas and toys are advised to have cleaning and disinfecting protocols in place to avoid the spread of infection.

- Follow up with any patient who experiences a nosocomial infection. Complete the appropriate work up and document it. If warranted, consider an infectious disease consult.

- Keep phone numbers for the infection control office at a local hospital, the local public health office, state health department and CDC easily accessible.

### References

- Burke JP. Infection control – a problem of patient safety. *N Engl J Med*. February 13, 2003. 348:7 651-656.
- Boyce JM. Epidemiology; prevention; and control of methicillin-resistant *Staphylococcus aureus* in adults. *Up to date*. Available at [www.uptodate.com](http://www.uptodate.com). Accessed October 21, 2005.
- Landers S. Handy advice: CDC asks physicians to come clean with gels. *American Medical News*. November 18, 2002.
- Gerberding JL. Hospital-onset infections: a patient safety issue. *Ann Intern Med*. 2002;137: 665-670.
- Bratzler DW, Houck PM. Antimicrobial prophylaxis for surgery: an advisory statement from the National Surgical Infection Prevention Project. *Clin Infect Dis* .2004; 38 June 15; 1706-1715.
- Whitehouse JD, Sexton DJ. Control measures to prevent surgical site infection. *Up to date*. Available at [www.uptodate.com](http://www.uptodate.com). Accessed October 20, 2005.
- Condon RE, Schulte WJ, Malangoni MA, Anderson-Teschendorf MJ. Effectiveness of a surgical wound surveillance program. *Arch Surg* 1983; 118:303.
- Olson MM, Lee JT Jr. Continuous, 10-year wound infection surveillance. Results, advantages, and unanswered questions. *Arch Surg* 1990; 125:794.
- Scheckler WE. Feedback of surgical-site infection rates to surgeons: recommendations, the data, and the current reality. *Semin Infec Control* 2002; 2:81-5.
- Weinstein RA, Siegel JD, Brennan PJ. Infection-control report cards – securing patient safety. *N Engl J Med*. 353:3 July 21, 2005; 225-227.
- American Thoracic Society, Infectious Diseases Society of America. ATS/IDSA guidelines: guidelines for the management of adults with HAP, VAP, and HCAP. *Up to date*. Available at [www.uptodate.com](http://www.uptodate.com). Accessed October 20, 2005.
- Tablan OC, Anderson LJ, Besser R, Bridges C, Hajjeh R. Guidelines for preventing health-care-associated pneumonia. 2003: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. *MMWR Recomm Rep* 2004 Mar 26;53.
- Alonso-Echanove J, Gaynes R. Prevention of intravascular catheter-associated infections. *Up to date*. Available at [www.uptodate.com](http://www.uptodate.com).

Accessed October 20, 2005.

- Belli A. Infection control; are our hospitals making us sick? *Houston Chronicle*. July 24, 2005.
- Friedman ND, Sexton DJ. General principles of infection control. *Up to date*. Available at [www.uptodate.com](http://www.uptodate.com). Accessed October 20, 2005.
- Glabmann M. The top ten malpractice claims (and how to minimize them). *Hosp Health Netw*. 2004 Sep, 78 (9): 60-2, 64-6, 2.
- Rubinstein E. Infectious diseases and litigation. *J Hosp Infect*. 1999 Dec;43 Suppl: S165-7.
- Miller JM. Liability relating to contracting infectious diseases in hospitals. *J Legal Med*. 2004. 25:211-227.
- Thies LM. As nosocomial infections increase, so may hospital liability. *14 Medical Malpractice Law and Strategy*. 1 1997.
- Pittet D, Hugonnet S, Harbarth S, Mourouga P, Sauvan V, Touveneau S, Perneger TV, and the members of the Infection Control Programme. Effectiveness of a hospital-wide programme to improve compliance with hand hygiene. *Lancet*. October 14, 2000. 356:1307-1312.
- Centers for Disease Control and Prevention. Guideline for hand hygiene in health-care settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HIPAC/SHEA/APIC/ISDA Hand Hygiene Task Force. *MMWR* 2002; 51.
- Pittet D, Simon A, Hugonnet S, Pesscoa-Silva CL, Sauvan V, Perneger, TV. Hand hygiene among physicians: performance, beliefs, and perceptions. *Ann Intern Med*. 2004; 141:1-8.
- Pittet D, Mourouga P, Perneger TV, and the members of the infection control program. Compliance with handwashing in a teaching hospital. *Ann Intern Med*. 1999; 130:126-30.
- Vandenbroucke-Grauls C. Clean hands closer to the bedside. *Lancet*. Vol 356 October 14, 2000.
- Weinstein RA. Hand hygiene of reason and ritual. *Ann Intern Med*. 2004;141:65-66.
- JCAHO. 2006 National Patient Safety Goals. Available at [www.jcaho.org/accredited+organizations/patient+safety/npsg.htm](http://www.jcaho.org/accredited+organizations/patient+safety/npsg.htm). Accessed October 20, 2005.
- O’Leary, D. Opening comments at the Infection Control Conference. November 17, 2003. Available at [www.jcaho.org/accredited+organizations/patient+safety/infection+control/oleary\\_statement\\_1117.htm](http://www.jcaho.org/accredited+organizations/patient+safety/infection+control/oleary_statement_1117.htm). Accessed October 20, 2005.
- Landers SL. Infection control reminders still necessary. *American Medical News*. March 18, 2002.

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# closed claim study

## Failure to diagnose retained surgical retractor

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 physicians' 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 and physician action

A 29-year-old man with a long-standing history of abdominal complaints was referred to general surgeon A for evaluation of a duodenal ulcer. After examination and evaluation, general surgeon A diagnosed a chronic peptic ulcer and recommended vagotomy and subtotal gastric resection.

The surgery commenced. A sponge count was completed at the end of the surgery, but an instrument count was not conducted and no instrument count was printed on the OR form. In the following weeks, the patient seemed to do well. He last saw general surgeon A eight weeks after the surgery.

Approximately 18 months later, the patient came to his family physician with complaints of severe lower stomach pain for three or four months. This physician noted the patient had undergone a partial gastrectomy 18 months prior. Over the next year, the physician provided conservative treatment. When this failed to alleviate his abdominal symptoms, the patient was referred to a radiologist for an air contrast barium enema.

Radiologist A reported that the films showed "a very large unusual radiopaque structure in the anterior abdomen. It appears very thin and flat and extends virtually the length of the abdomen. It is located anteriorly and may be superficial in the anterior abdominal wall, although its exact location and etiology is not known. It may be related to the patient's midline incision, aside from this the patient's abdomen appears unre-

markable on the scout film."

Two weeks later, the patient saw a gastroenterologist on referral from his family physician. The gastroenterologist did not have the patient's records or radiographic studies available at the time of the examination. He believed the patient suffered from chronic abdominal pain syndrome, but he planned to locate the patient's records and evaluate them. The records were relayed to the gastroenterologist, including the barium enema study that noted the radiopaque material in the abdomen. The gastroenterologist concluded this material was an unusual form of surgical mesh related to the patient's surgical procedure. He believed that the patient was suffering from prostatitis and felt there was not a GI source for the symptoms. No further GI work up was needed.

Three days after his final visit to the gastroenterologist, the patient came to the emergency department of hospital A. He complained of lower scrotum and abdominal pain, and was seen by ED physician A. An abdominal x-ray was ordered and was read by radiologist B. He concluded "there is an anteriorly located 'mesh' in the subcutaneous tissue most likely related to an abdominal anterior wall hernia correction. There are several surgical clips in the left upper quadrant and surgical staple line to the right of the mesh at the L2 level. There are dense probably residual contrast collections either in the appendix or Secale region in the lower right quadrant. The bony structures are unremarkable. There are minimal degenerative changes." Radiologist B believed there were surgical changes in the abdomen with no evidence of acute abdominal process. ED physician A diagnosed acute prostatitis, and advised the patient to continue taking the medication prescribed by the gastroenterologist.

Over the next year, the patient continued under the care of the family physician. The medical records indicate the patient continued complaining of abdominal pain.

Three years and 10 months after the surgery, the patient came to the ED at hospital

B. ED physician B's impression was that the patient suffered from acute abdominal pain, left ureterolithiasis, and hematuria with a high grade left renal ureter obstruction. ED physician B noted in his chart that there was an intra-abdominal metallic foreign body. A urologist examined the patient and reviewed the IVP with radiologist C. They both noted a small distal left ureteral stone and a metallic density on the film, which they believed to be mesh related to the patient's prior surgery. The urologist discharged the patient, as he was pain free.

The patient returned to the ED five days later and was seen by the same urologist. He felt the patient was suffering from a left ureteral stone and ordered the patient's admission. The next morning, the patient was pain free. The urologist encouraged him to increase the pain medication, to strain his urine and attempt to pass the stone. The patient was discharged and told to return to the urologist in one week. The patient did not return to the urologist. However, after receiving a notice of claim regarding this patient, the urologist made two additional entries into the patient's chart indicating the patient failed to keep appointments.

Two years after the visit to hospital B, (now five years and nine months after the surgery) the patient came to the ED at hospital C complaining of abdominal pain. An x-ray was reported as unremarkable, but the patient reported that he was known to have a wire mesh in his abdomen. The impression by ED physician C was acute abdominal pain. The patient was seen again in the ED of hospital C nine days later. The x-ray report noted metallic clips in the upper portion of the abdomen due to the prior surgery which two wide plates superimposed over the right paravertebral region, possibly representing a back brace. The x-ray was again reported as a negative x-ray of the abdomen.

Following these two visits to hospital C, the patient came to general surgeon B who ordered a CT scan and reviewed the previous abdominal x-rays. General surgeon B diagnosed a retained metallic foreign body,

probably a surgical ribbon retractor, as the cause of the patient's pain. The patient was taken to surgery, and the surgeon found and removed a 3-inch-wide x 13-inch-long surgical ribbon retractor.

The patient's records indicate that he had not undergone any other abdominal procedures other than the vagotomy and subtotal gastric resection. It appeared that the retractor was left at the time of this surgery.

The patient testified that since the removal of the retractor he has experienced no other abdominal complaints.

### Allegations

A lawsuit was filed against general surgeon A and the hospital where the surgery took place, alleging negligence in leaving a ribbon retractor in his abdomen during the surgery. The patient also filed suit against all the physicians who treated him after the surgery, alleging negligence in failure to diagnose the retained retractor. Named in the suit were the family physician, the gastroenterologist, the urologist, the three ED physicians, and the three radiologists. This incident was featured in a news story on medical mishaps and aired on a network investigative news program.

### Legal implications

The plaintiffs in this case effectively developed their case to pursue two claims: the act of leaving the retractor and the subsequent failure to diagnose it. The surgeon who removed the retained retractor provided a report critical of all those involved in the first surgery.

Defense radiology experts were critical of radiologist B for describing the metal as

"mesh," and that this description led to a delay in diagnosis and removal of the foreign object. This report should have triggered further work-up by the referring physician. The consultants also concluded that radiologist A's report fully described the retractor, and that the referring physician should have followed up on that report.

Other defense consultants were not entirely supportive of the actions of the urologist and the gastroenterologist. The main weakness in the case against the gastroenterologist was the failure to follow up on the cause of the patient's abdominal pain and the radiology report submitted by radiologist A. Regarding the actions of the urologist, he was under the impression that the prior physicians and the patient were aware of the foreign object based on the previous radiology studies. However, other urology experts were critical of his apparent inability to recognize the retained object as a surgical retractor. The urologist's alteration of the medical record also undermined his defense.

As is often the case when claims involve multiple defendants, finger pointing became an issue. The plaintiff's attorney was able to develop conflicting testimony and criticisms between the various subsequent physicians. This, coupled with the damaging testimony from the plaintiff's own experts, significantly hindered the defense of this case.

### Disposition

Given the "shock value" of this case and the difficulty in obtaining supportive defense testimony, this case was settled with the consent of the physicians. Settlement

was made on behalf of general surgeon A, the gastroenterologist, the urologist, and radiologist B. The case against radiologist A was dropped. The hospital where the surgery took place also settled this case. The outcome of those suits against the other defendants is unknown.

### Risk management considerations

There could not be a more compelling example to justify instrument counts in the operating room. The summary of this claim tells the story. It is difficult to comprehend that it took almost six years, visits to multiple hospitals and physicians who ordered many tests to accurately identify the etiology of the plaintiff's complaints.

An action requiring comment is that of the defendant urologist who, after notice of claim, made two entries in the medical record regarding appointments that were not kept by the plaintiff. Physicians and their practices are encouraged to implement a "no show" system that is used in a timely manner. Document in the record that the patient did not keep their appointment. Contact the patient and document this action in the record.

A late entry or addendum in a medical record is to be clearly identified with the current date of documentation and the date referenced for the added information. Once a physician has received a notice of claim, it is inadvisable to add any notes to the medical record.

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## legislative update . . . continued from page 3

### Senate Bill 465 — administration of psychoactive medication

Expands the application requirements for a physician to request a court order to permit the administration of psychoactive medications to a patient refusing the medication.

### House Bill 984 — students with diabetes

For every student with diabetes in Texas public elementary and secondary schools, a personal diabetes management and treatment plan must be developed by the student's parent/guardian and physician.

### Medicaid

Restored podiatry, eyeglasses, and hearing aid benefits for adults.

### CHIP (Children's Health Insurance Plan)

Restored dental, vision, hospice, and mental health benefits. Established perinatal benefits.

- A physician (not just ob-gyns) who provides Medicaid services to a pregnant woman shall inform the woman of the CHIP benefits for which she or the woman's child may be eligible.

### Texas Medical Board (formerly the Texas State Board of Medical Examiners)

The 2005 Texas legislature made wide-ranging changes to the laws related to physician's practices. The Board is now working (with stakeholder input) to adopt rules in accordance to those changes.

- Reduced fees and CME requirements for retired physicians who provide only charity care. Liability insurance shall also be made available to charity physicians. Retired physicians providing care through a disaster relief organization are exempt from the registration fee.

- Prescription delegation to a registered nurse or physician assistant need not be registered with the TMB. However, records must

be maintained by the physician.

- Requirements for TMB mental or physical examinations were expanded to include applicants, not just licensees. Examination can be required only in cases involving mental/physical health conditions, substance abuse or professional behavior problems.

- TMB must publish its disciplinary action errors and reversals in the same manner it published the original action.

- Removed the statutory exemption from Office-based Anesthesia rules for physicians who use only moderate sedation. Physicians must now follow the TMB's Office-based Anesthesia rule when administering anxiolytics and analgesics even if there is no probability of placing the patient at risk for loss of life-preserving protective reflexes. The Office-based Anesthesia rule requires:

- annual registration and compliance with detailed standards; or
- certification or licensure of the facility.

# the Reporter



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## ethics exchange . . . continued from page 7

the same sentiment in finding that physicians have complete freedom to choose their patients, but should not refuse to accept patients because of race, color, religion, sexual orientation or national origin.

Along with policy statements about the right to choose patients, there are cautions against abandoning patients. The AMA's first code of ethics, written in 1847, states that it is the physician's "moral duty... not to abandon a patient." Texas law clearly provides that the physician shall give due notice to the patient, family or those responsible for the patient's care when withdrawing from the case so that another physician may be engaged. The physician's right to choose is not intended to imply that a physician accepts only those patients whom it is convenient and enjoyable to accept. At the same time, discretion must be used regarding the timing of the refusal or termination. The patient is entitled to continuing treatment until the present illness is sufficiently stabilized in order to allow safe transfer of care to a willing physician.

If the physician terminates the relationship and if there is no emergency condition,

or the patient is not within a current course of treatment (e.g., late stage of pregnancy), the patient should be given a written notice of termination, usually 30 days from the date of notification. The physician may, but does not need to enumerate the reasons for termination of the relationship. The physician does not need to find another physician for the patient, but it is reasonable to provide some assistance such as providing the phone number of the local medical society.

### Sources

1. Peabody FW. The Care of the Patient. *JAMA*. 1927; 88: 877-82.
2. Snyder L, Weiner J. Ethics and Medicaid Patients. In: Snyder L, ed. *Ethical Choices: Case Studies in Medical Practice*. Philadelphia: American College of Physicians; 1996; 63-70.

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In determining which patients a physician will treat and which he/she won't, it is clear that economic criteria and the basic right of a physician to choose patients are accepted by long-standing tradition and by law. These physician rights are balanced by our obligation as caregivers to provide collectively for

all within our society. We must also recognize and obey the legal and ethical requirements about the proper way to end the doctor-patient relationship.

In this case, the urgent care clinic failed to meet the criteria discussed in this article. They did not indicate to new patients, or adequately warn existing patients, that they did not accept Medicare. They did not offer to continue care under a self-pay basis, nor did they assist their patient in finding alternative care. As a result, the urgent care clinic exposed itself to a charge of abandonment. This could have had significant consequences if the patient had suffered a serious complication from untreated hypertension before being able to access medical care.

Of course, the elephant in the room is whether or not it is ethical to deny care as patients reach their 65th birthday. Although it is not mandatory to participate in the Medicare program, unwillingness to do so is, de facto, denying care to most people age 65 and older. That is a question each physician must answer for himself or herself.

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