the Reporter

TMLT
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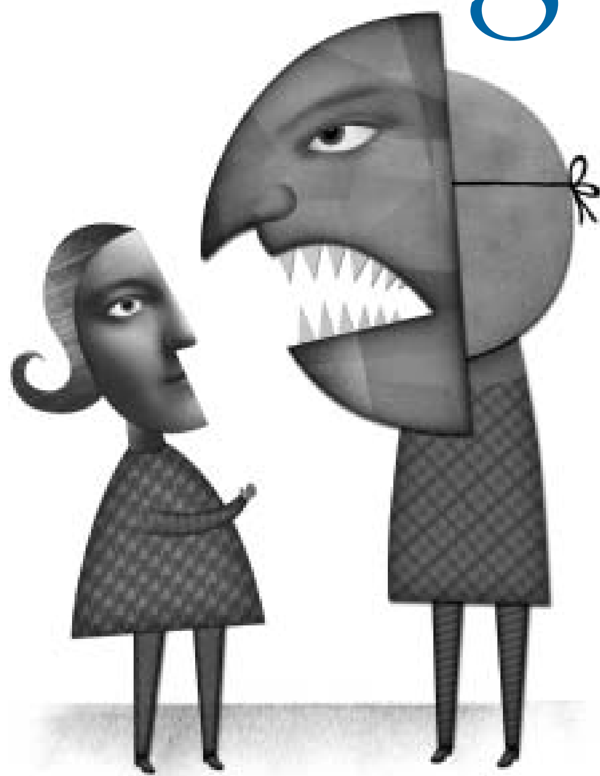
Defusing angry patients



by Barbara Rose

In an informal poll of TMLT risk management representatives, all reported an increasing number of physicians or their staffs seeking advice for dealing with angry, difficult, or noncompliant patients. While anger is a normal human emotion, "dealing with anger and conflict in the context of the patient-physician relationship can be quite tricky." [1]

Angry patients and family members pose a significant challenge for a physician. "Encountering this type of tense emotion often triggers one's own fight-or-flight responses." [2] Anger begets anger and movement toward a resolution is stopped. The physician and staff are the health care professionals in these scenarios and need to remain calm and empathetic. "There are communication skills that can be used to defuse anger and re-establish effective dialogue with patients and their families." [2]

Frequently, the source of anger is a person or situation unrelated to the physician. Patients feel a loss of control when health insurance changes and they are forced to select a different physician for their care. Patients may arrive at appointments frustrated or angry because they got lost or were unable to find a parking place. Perhaps anger is masking fear. The following techniques may help determine the source of the patient's anger.

- Be curious; ask why they are angry as this may have a therapeutic effect.
- Don't be defensive and engage in a power struggle.
- Listen carefully; this alone may defuse the patient's anger.

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• Use active-listening techniques — repetition, summary, validation, and empathetic statements.[2]

When physicians are uncomfortable interacting with a patient, a barrier to effective communication exists. "Being aware of the tension, identifying the barrier, and acknowledging with the patient that there is difficulty in the relationship are important steps in re-establishing understanding between a patient and clinician." [2]

In *Anger Management Techniques,* J. Alfonso describes visceral responses that may defuse a heated encounter with a patient.

• Maintain slow and steady breathing.
• Monitor the pace and tone of your voice. Speak slowly and calmly.
• Maintain open body language as a nonverbal sign of listening. [3]

Also, avoid standing with your hands on your hips, in your pockets, or arms crossed as this body language connotes a defensive reaction.

What if the source of the anger legitimately rests within your practice? A patient who experienced difficulty in scheduling an appointment, a long waiting time, or unresponsive staff members will very likely direct anger toward the physician. Use the techniques listed above. Get specifics and give the patient assurance that the matter will be acted on and resolved. Don't avoid the angry or dissatisfied patient. Being an advocate for your patients will enhance your effectiveness. "As difficult as it may be, the more you talk with and listen to an angry patient, the more likely you are to avoid converting an incident into a claim." [4]

Another model for dealing effectively with critical and angry patients triggered by events in your practice suggests the following:

1. Make a disarming statement, e.g. "You are right. You did have to wait today." This is non-defensive and validates some of what the patient is saying.
2. Make an empathic statement, e.g. "Your time is important and it is frustrating when you have to wait." This reflects putting yourself in the patient's position and understanding his or her needs.
3. Make an inquiry, e.g. "What can we do to resolve this problem today?" This demonstrates your shared relationship and interest in the patient and may move the exchange to a productive solution. [5]

Most confrontations can be resolved safely. However, there are times when these techniques will fail, and the patient's anger will escalate to hostility or violence. If that occurs, have a plan for physician and staff safety, and do not hesitate to call security or the police. In light of such events, you may decide to terminate your physician/patient relationship unless such an episode was triggered by an acute episode of mental illness or the aberrant behavior surfaced as a consequence of patient/family crisis.

Pain and fear can lead to increased anxiety and frustration that may progress to anger and to loss of control. This process is not always obvious. Do you know how to detect anger early and take steps to defuse it? Warning signs that indicate a deteriorating emotional state may include a clinched jaw or fists, tense posture, fidgeting, a raised voice. Do not ignore these signs and do not rush the patient through the visit. Doing so may prove detrimental to the patient's care and may increase your risk of liability. Documenting displays of anger and complaints, as well as efforts at resolution and the outcome of each intervention may deflect a frivolous claim or aid in a physician's defense. [6]

A practice administrator with 20 years experience recently opined that "health care has become impersonal" and this affects both patients and physicians in a negative way. What should physicians do? There is no easy solution, no magic formula, and no guide to guarantee success. Don't act arrogant or omnipotent. "By creating an atmosphere of trust and partnership, you can relieve your patients' anxieties and diffuse their anger. Without anger or hostility, you and your patients can work together as partners to decide their medical care plans." [4]

Sources

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tmlt perspective

TMLT announces rate reductions, declares $10 million dividend

TMLT declares $10 million dividend

In an unprecedented decision, the TMLT Board of Governors voted to pay policyholders an annual dividend based on Trust earnings and strong capital position, beginning January 1, 2006.

The dividend declared for 2005 is $10 million. Dividends will not be paid by check, but will be credited to your premium as a lump sum when your policy renews. You must renew your policy with TMLT to receive this dividend.

The Board of Governors will determine the dividend amount each year, as financial results permit. Dividends will apply beginning with January renewals.

TMLT to reduce rates by 5%

TMLT will again reduce rates by 5% effective January 1, 2006. Current policyholders will receive this rate decrease when their policies renew. Since House Bill 4 and Proposition 12 took effect in 2003, TMLT policyholders have seen their rates decrease three years in a row — 12% in 2004; 5% in 2005; and another 5% in 2006. These reductions have not been matched by any other carrier.

"In the more than 20 years that I have been with TMLT, I have never seen rates decline for such an extended period of time," says Tom Cotten, President and CEO of TMLT.

"Medical liability reform continues to triumph in Texas. The malpractice environment in Texas is recovering well," says Dennis J. Factor, Chairman of the Board of Governors. "TMLT will enter 2006 in a strong financial position. And, as a physician-owned company, our success is your success. We are passing this on in the form of dividends and rate reductions."

Changes to experience discount, surcharge program announced

During the 2005 Texas legislative session, a law was passed that requires Texas insurance companies to review their premium discount and surcharge programs. This legislation, House Bill 2678, prohibits the consideration of legal expenses in setting a rate for a policyholder unless the claim results in an indemnity payment.

HB 2678 mandates that policyholders who have incurred only legal expenses, regardless of the number of claims and the amount paid, cannot be disqualified from a company's experience discount program. The Board of Governors voted to voluntarily participate in this program as well. Currently, TMLT policyholders with 3 years of favorable experience are eligible for the Experience Discount. The discount is 2% per year and is capped at 20% after 10 years. Changes to the Experience Discount include:

- policyholders who have incurred legal expenses only will continue to qualify for TMLT's Experience Discount;
- only sizeable indemnity payments, which generally are paid out after significant legal expenses have been incurred, will reduce the amount of the discount; and
- two or more indemnity payments of any amount disqualify a policyholder from the Experience Discount.

Each year at renewal, the Experience Discount is evaluated and factored into a policyholder's renewal premium. These changes — which will benefit 5,308 policyholders and increase the discounts from $7.4 million to $19.5 million — will take effect on January 1, 2006.

TMLT has also made changes to its surcharge program. These changes, which affect only a small number of TMLT policyholders, will be explained in a letter to those as their affected policies renew.

The bottom line: how these changes add up

2005 available discounts	**2005 discount amounts**
	$9,500 base premium
	(includes 2005 5% rate reduction)
Practice review discount (3%)	-$285
Experience discount (6%)	-$553
(after 3 years favorable claim experience)	
Total 2005 premium	**$8,662**

2006 available discounts	**2006 discount amounts**
	$9,025 base premium
	(includes 2006 5% rate reduction)
Practice review discount (5%)	-$451
Experience discount (8%)	-$686
(after 4 years favorable claim experience)	
Total 2006 premium	$7,888
2006 dividend (5% of expiring 2005 premium)	-$433
(applied as a payment toward 2006 premium)	
Final 2006 premium	**$7,455**

Practice review discount increased to 5%

As a way of rewarding those policyholders who play an active role in reducing their liability risk, the Board of Governors has elected to increase the discount for physicians who complete practice reviews from 3% to 5%. There is no dollar-amount limit for this discount, and the discount continues through the expiration of the current policy plus two full policy periods. For policyholders who currently receive the practice review discount, the increase to this discount will apply when your policy renews.

Practice reviews are free to all policyholders and involve an on-site evaluation by a TMLT risk management professional to help determine risk exposures. Request a practice review at www.tmlt.org or by calling the risk management department at 800-580-8658.

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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:

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 Danielle T. Burkett, Rodolfo Jose Oviedo, Bradley Lega, and Rebecca Wald are printed in this issue of *the Reporter*. The essays by Erin K. Shiner, Jesse Lee Even, and Jedidiah J. Grisel will be published in the November-December issue of *the Reporter*.

By Danielle T. Burkett

Law X: "If you don't take a temperature, you can't find a fever." — *The House of God.* Although this statement seems obvious, it appropriately points out that a physician with incomplete information cannot arrive at the proper diagnosis. This lack of information puts both the patient and the physician at risk. In today's complex medical environment, maintaining and increasing patient safety, and thereby reducing the risk of malpractice suits, is a daunting yet crucial task for physicians. However, the benefits of undertaking this task accrue not only to the patient through decreased risk, increased efficacy of treatment, and improved quality of life, but also to the physician through decreased malpractice risk and increased ability to provide quality health care. Creating such benefits requires that physicians take initiative to assure accuracy of information through meticulous history-taking, thorough education, and careful clarification of all aspects of a patient's care.

The physician must first ensure that the patient accurately communicates all pertinent health information. In order to elicit a reliable history, a doctor should create an atmosphere of trust by assuring the patient that the interview is confidential. He or she should put the patient at ease and approach the patient in a manner that conveys genuine concern but also respect for the individual. Taking these steps will make the patient more likely to reveal sensitive information relevant to their overall health.

Observation also plays a crucial role in the assessment of patients. Careful attention to the patient's demeanor, dress, speech, body language, and movement may reveal critical details about the presentation. Overlooking such information could lead to erroneous conclusions and misdiagnoses.

When beginning the interview, the physician should first allow the patient to explain their situation without interruption in order to acquire what a patient feels is relevant history. They may relate details about which the interviewer might fail to ask. More importantly, however, by allowing the patient to express their history uninterrupted, the physician can avoid the trap of leading a patient to a presupposed diagnosis.

Following this initial narrative, physicians must be prepared to ask detailed questions regarding the patient's medications. Inquiries related to medications have generally been included as part of taking the patient's history, but because the scope of prescription medication, over-the-counter medication, and herbal supplements has increased dramatically, the physician must now question the patient more completely to ensure that conflicts do not arise between current and future treatments the patient may undergo. Patients often forget or do not find it necessary to include their use of over-the-counter medications and herbal supplements in their histories, so inquiries must be made about these substances in particular. Dosage, frequency of use, compliance with directions, and reactions and side effects of these medications must also be obtained. Furthermore, the doctor should ask about previous treatments and reactions.

Unfortunately, physician inquiries into the patient's lifestyle, habits, and emotional state have been less frequent and less detailed than similar attempts to learn about the patient's medications. Physicians do not want to offend patients or make them uncomfortable, or they make the mistake of assuming they know the answer. While these may be uncomfortable to discuss, issues such as sexuality, illicit drug use, and depression can be of utmost importance, giving the physician insight into risk factors that must be addressed in the patient's treatment plan. Patients are reluctant to voluntarily divulge such information, making it imperative that the physician bear the responsibility for incorporating such information into the patient interview in a professional and respectful manner.

The information that the physician communicates to the patient is equally vital to the patient's health care. There are several areas that the physician must address. First, the patient should receive an explanation of their current illness including associated risks and what they can expect in the future. Second, the physician should address treatment options with the patient. It is imperative that the patient understands the risks and benefits of all options, including the choice to not take action. Together, the patient and physician should weigh these options and decide on which approach will best serve the patient. A thorough discussion should include not only medical and surgical options, but lifestyle modifications that will improve the patient's overall health and decrease

risk of future disease or complication. Failing to properly educate the patient can result in a lack of compliance from the patient which would most certainly decrease the patient's safety and increase the physician's exposure to malpractice claims.

Finally, the physician has a responsibility to clarify all information. During the interview, this requires confirming key aspects of the history of the patient. When giving treatment plan instruction, the physician needs to ensure that the patient completely understands all instructions. While it is important to ask the patient if they have questions, one should be sensitive to the fact that the patient may be unwilling to openly admit a lack of understanding. Overcoming these hurdles to patient safety can largely be accomplished by simply speaking slowly and clearly in terms that the patient can understand and asking the patient for feedback to assess their comprehension of any instructions or explanations. Trying to anticipate any questions is helpful. Writing instructions down is another way to assure compliance. Often, instructions that seem common or simple to the doctor may be more complicated to the patient who will be likely to forget such complicated details. Providing written instruction prevents this problem. Finally, the physician should reassure the patient that if any problem arises or they think of questions later, they can contact the office for further information.

Increasing patient safety begins with increasing the quality of information flow between the patient and the physician. It is a dynamic process requiring diligence and flexibility to improve the quality of medical care. Although time consuming, the value of obtaining complete information will prove to outweigh the cost by increasing the overall level of patient safety and reducing the risk of malpractice litigation.

By Rodolfo Jose Oviedo
It shall be for the good of the sick

"I do solemnly swear, by whatever I hold most sacred . . . That into whatsoever house I shall enter, it shall be for the good of the sick to the utmost of my power . . ." The Physician's Oath of Hippocrates is still recited with devotion and pride by the privileged ones who enter the most beautiful and fascinating profession in the world, the one profession that was born when human beings began to care for each other and that continues to be practiced by fragile but determined people who have sworn to dedicate their efforts and sacrifices to the assistance of the ill: medicine. Nonetheless, in spite of the selfless character of this way of life that society still regards as one of its noblest professions, it is disconcerting to know that physicians are being treated with distrust by those to whom they have sworn to protect and save from illness, their own patients. On the 21st century of the modern era, the term "defensive medicine" has come to acquire an almost official validity and is used by doctors as though by saying it they felt more secure and aware that the potential for a legal suit is always imminent, awaiting them on any given day of their practice.

It is amazing to realize that in this great country, where the technological advances of medicine have put physicians on the summit of patient care in terms of procedures and treatments that were unimaginable some decades ago, that patients are losing trust in their doctors. Many have lost respect after numerous unfortunate experiences in which they have felt mistreated or ignored; when their right to autonomy has been violated; and their need to know about their diseases has not been addressed by the medical professionals, either consciously or unconsciously, by negligence or on purpose. What can we do, as a rational and organized society, to understand the nature of this critical problem and commit ourselves to the quest for a solution that surges from the very roots of the problem? The safest way to do it is by humbly admitting that we, as doctors in training and consecrated professionals with years of experience, have made a terrible mistake by distancing ourselves from a reality that has been known for centuries: that physicians must learn to be, above all things, excellent communicators and protectors of the mind and soul of their patients. Human beings have many needs, but one of the most fundamental is meaning. We as medical students and physicians should emphasize personal communication and public relations skills in our training and daily lives so that we can fulfill patients' need to understand their diseases and their meaning to their lives with dignity and freedom to choose their destiny.

As a concrete solution to the problem of patient safety and the risk of malpractice suits, medical students and residents should receive formal training on ethics and humanities, not just as a class taken for a semester or two, or as a number of credits that must be met, but as a permanent and familiar philosophy during the entire medical school and residence experience. Future doctors will know how to prioritize their patients' dignity and right to know about their diseases and treatment options. If we learned how to consider our patients' questions as hints about their deeper needs and provided them with enough information for them to make their own informed decisions, the situation would be different and a more favorable one for our health care system. Physicians in practice can sacrifice some time by spending a few more minutes discussing their diagnosis and treatment modalities with their patients so that the latter learn how to take care of themselves and begin to practice preventive medicine before it is too late and their diseases have advanced to a point where intervention is required. Physicians can always spend a few more minutes to counsel their patients and advise them to join support groups where other people in their situation share their experiences on how to control their chronic diseases, such as hypertension or diabetes, with lifestyle changes.

In addition to implementing communication, ethics, and humanities curricula in medical schools and residency programs, we should make these areas of human understanding requirements for certification of our licenses so that we may prevent arguments with our patients and future malpractice suits because of lack of communication. Sometimes it does not take a complication from a procedure or the wrong choice of antibiotic to upset a patient. Rather, it takes the patient's realization that his or her doctor did not care about explaining the possible outcomes and treatment alternatives. Of course, the potential for a lawsuit will always be there, but we can certainly minimize that potential by practicing a more human type of medicine.

It is not an impossible task. If our physicians committed themselves to ensuring that their patients learn how to cope with their diseases and prevent others, and provided them with enough information so that they decide what to do, the patients would not feel that they need to sue their doctors should an unfortunate complication develop. It would simply be unnecessary, and hopefully, unthinkable, for them to take their doctors to court because they would know that those physicians took their time to treat them with respect and practice their profession "with uprightness and honor." We should always try to educate our patients and heal them instead of focusing on treating diseases that pose challenges to our intellect. To ensure patient safety, we as doctors should indeed practice "defensive medicine," but not to defend ourselves. The ones that we have sworn to defend from illness and suffering are the patients.

By Bradley Lega

Hunter S. Thompson, the author of *Fear and Loathing in Las Vegas* and *Fear and Loathing on the Campaign Trail*, recently shot himself. This is a shame for many reasons, but one of them is that he never had the chance to write a book called *Fear and Loathing in a White Coat: A Chronicle of Doctors, Lawyers, and Malpractice.* Fear and loathing seem like two most appropriate concepts to describe the average physician's view of malpractice: fear of being sued, loathing for the wolfish lawyers that patrol the flanks of medical practice looking for the weak and the old. The fear begins early in training as professors emphasize points about disease management with phrases like: "And if you don't do this, start finding a lawyer." The loathing comes from many sources, including unending TV ads for Jim Adler the Texas Hammer, an over-exposed malpractice attorney who evidently takes advice from professional wrestlers.

After starting clinical rotations, I noticed that loathing associates itself with malpractice in another, more subtle form. Stories of lawsuits become a way for residents to express their dislike for their peers. During my medicine rotation, the team's intern complained about how lazy one of the surgery residents was, and then added, "He's already been sued twice." The story is petty, but it shows that physicians often think that their less competent and careful peers are the ones being sued, that a lawsuit is something like a professional scarlet letter. The advice these physicians give about malpractice reflects their attitude — I can't count how many times I've heard the sentence "If you do what's best for the patient, you won't be sued."

I call this method of malpractice avoidance the Edwards method, after the Puritan preacher whose sermon "Sinners in the Hands of an Angry God" has some legendary metaphors about the consequences of immorality. In the Edwards method, if a physician does what she's supposed to, she can live with a clean conscience and without fear of legal reprisal. The method theoretically ensures infallible patient care: if a physician always does what's best for the patient, then patient safety should be one of her prime concerns. But what's best for the patient? The conventional term "standard of care" is a fluctuating and nebulous concept, especially for unusual cases. Plus, bad things happen to good people: innocent women were drowned as witches, pious Franciscans caught the plague, and good doctors suffer lawsuits.

This last point leads to a second often-repeated prescription for avoiding malpractice: documentation. If a physician carefully documents what she does and her reasoning behind difficult decisions, her defense lawyers will have powerful weapons to keep the wolves at bay. I call this the Nixon method, since Nixon's tapes illustrate how documentation can cause problems for people who aren't doing what's right. The Nixon method's emphasis on documentation implies that a physician must maintain constant vigilance, thinking of each page in the patient's chart as a piece of evidence of her own defense. It also contributes to the adversarial nature that pervades too many doctor-patient relationships, a trend that can't be good for patient safety no matter how artful the argument. Finally, in my limited experience, mistakes often occur when doctors forget to do things that they normally would do — forgetting to recheck a patient's potassium level after ordering an ACE inhibitor, for instance. But the Nixon method does nothing for these types of errors, since a physician can't document something she forgets to do.

It appears then that serious flaws weaken both the Edwards method and the Nixon method, even though they are the basis for 70% of the advice that medical students hear about malpractice. I think an approach that I call the Aristotle method solves some of these problems and could serve as a model for how physicians avoid malpractice and promote patient safety. The Aristotle method is built around virtue, as is Aristotelian ethics. It stems from the observation that physicians-in-training learn their habits by emulating some of their superiors, especially residents, attendings, and other students who have won the respect of their peers. Co-workers attribute virtues such as "hard-working," "sharp," "strong," and "efficient," to these role-models, but the Aristotle method doesn't mean that physicians can avoid malpractice by being stronger and sharper. It means that when taking care of patients, students should imagine themselves verbalizing their analysis and decision-making to one of their professional heroes. This mental exercise finds potholes in reasoning, and the act of forcing oneself to construct a coherent narrative helps identify things that the physician may have initially forgotten to do.

The Aristotle method is not the same thing as asking inane self-questions like "What would Osler do in my position?" It advocates mental recapitulation, not simple mimicry. We may find that we disagree with our role models' imagined opinion, but we should then be able to offer good reasons for doing so. And if we honestly don't know what he or she would think, then it might be time to consult the literature. This idea may initially seem similar to the Edwards model, in which physicians practice in constant fear of judgment for deviating from some standard, but I think it's more positive since most of us want to win recognition of the people we look up to and we're willing to work hard for it. And by thinking about what a specific person's thoughts or criticisms might be, it avoids the vagueness inherent in "standard of care." It may also look similar to the Nixon model, since documenting one's reasoning generates the same kind of narrative as imaginary verbalization. But I think it's less cynical since it creates habits from virtue rather than lawsuit avoidance, and it actively helps prevent errors of omission.

As with any good practice, the Aristotle method could be instituted if the professionals we respect tell us that it's a good idea. I think it's a way that avoiding lawsuits and promoting patient safety can converge.

By Rebecca Wald

For the holidays this year, I received the gift of time with my father. My dad was diagnosed with prostate cancer in October, and I will never forget his voice saying, “Rebecca, they found cancer.” The emotions began to flood, and I realized that my “invincible” Dad might not always be there for support and love. As I sat by his hospital bed, the importance of patient safety was not just a medical record number on a chart, it held the face and name of someone so dear to me. In an ever-changing and advancing health care system, it is more important than ever to ensure patient safety and satisfaction. I believe there are several simple measures that each individual physician can do to ensure patient safety and minimize the risk of medical malpractice suits. These measures can be broken down into four areas: a physician’s clinical communication, their relationship with the patient, interaction with the nursing staff, and the physician’s own health maintenance. Working with these four areas will help each individual physician ensure patient safety and decrease malpractice suits.

As the numbers of physicians and nurses seeing each patient increases, the importance of each physician’s communication is critical. Proper and pertinent information must be shared between medical personnel to efficiently treat each patient in a timely manner. An easily overlooked way a physician can improve patient safety is by writing legibly. If one’s handwriting is not legible in the chart, the orders may be misread, the following physician may miss key findings, and the patient may be placed in harms way. Each physician should also summarize in progress notes daily: an overview of the medical history, the current hospital course, treatment plan, preventative care, current medications and doses, and if they have spoken with a family member.

The second area a physician can improve patient safety and decrease malpractice suits is in their interaction with the patient. Thorough hand washing, relentless glove usage and proper isolation precautions should be followed to decrease infectious spread. The physician should also keep up-to-date on the latest medical information. Patients are now more informed with greater access to sources like the internet, and the physician must be ready to explain why certain measures are being taken versus those that the patient may have researched online. Most important of all concerning patient safety and satisfaction is establishment of a good rapport with the patient. This is a lesson that was taught to me by my sister who is an obstetrician/gynecologist, a specialty in which malpractice rates are high. A physician must care for their patients, cry with them, be joyous with them, and express that they are in the battle together. A patient that feels their physician is genuinely concerned for their health and well-being will be more satisfied with their patient care and more compliant with treatment and follow-up plans.

Establishing a good rapport starts as soon as the physician first interacts with the patient. The few minutes one has to spend with each patient should be quality time that expresses one’s concern for the patient. Little things like eye contact, smiling, and sympathizing with the patient go a long way. Also, to decrease confusion, physicians should introduce themselves and give the patient a business card with their specialty written on it. For example, a nephrologist may write “kidney doctor.” When an additional doctor sees the patient, they may also introduce themselves with a card and say whom they are covering for. This will allow the patient to feel less overwhelmed by the large number of individuals in charge of their care. Additionally, work with the family to help them understand the procedures, results, and make them feel involved. Finally, explain results and reasons for treatment in words the patient can understand, and be sure to ask if they have any questions.

The third area a physician can increase patient safety and decrease malpractice suits is by good relationships with the nurses who are also key to patient safety and satisfaction. My mother, who has been a registered nurse for almost 40 years, always taught me one important lesson: nurses are invaluable. Listening to their input and recognizing them as part of the team can dramatically improve the level of health care provided and patient safety. Each physician should get to know their nurses, thank them for their help, respect their opinions, encourage suggestions and keep an open line of communication. Many nurses have a great deal of knowledge and intuition from experience and can help the physician better treat the patient and often avoid inappropriate or misunderstood orders. Also, the respect a nurse has for a doctor is easily viewed by the patient and influences patient satisfaction and compliance with care.

Lastly, the physician’s personal health maintenance is often overlooked, but vitally important. If the physician is not at their highest mental capacity due to lack of sleep and exhaustion, the patient’s safety is in jeopardy. Recent measures to decrease resident weekly hours are a step in the right direction to improving patient safety. In addition, each physician should realize that the advice they give to their patients holds true for themselves as well: eating healthy, exercise, and getting adequate rest. Of course, universal precautions should be second nature to ensure the health of the physician against injuries or transmission of diseases.

By taking measures toward improving patient safety in the four mentioned areas: clinical communication, relationships with the patients, interaction with the nurses, and one’s own health maintenance, each physician can work to improve safety and decrease malpractice suits. Every patient is someone’s father or mother, sister or brother, son or daughter, husband or wife. Each deserves the best we have to give. When we treat each patient as if we were treating our own family member, we will be stepping towards better health of each patient and will allow the gift of more time, like I had with my father, to be given to all.

EXPIRED CME

From Hippocrates to the AMA

Historic perspective and modern application of medical ethics

Objective

After completion of this educational activity, the reader will be able to analyze an ethical scenario by identifying applicable information and applying principles of ethical decision-making.

Course author

Catherine Stidham is a risk management representative at TMLT.

Disclosure

Catherine Stidham 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 September 23, 2005, and expires on October 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.

A glimpse into ancient history

Greek legend has it that the god Apollo "invented" healing. This sacred knowledge

was eventually passed on to Asclepius, who was later worshiped. At this point, it is arguable, that the "religion" of medicine began. [1] Asclepius was already worshiped throughout the Greek world when Zeus made him into a god and transformed him into the constellation of the serpent-bearer. Snakes were an integral part in the healing ritual, as patients would sleep overnight with nonpoisonous varieties to achieve healing.[2] Asclepius was eventually known and differentiated in the art of healing by a physician's staff with an Asclepian snake wrapped around it. This attribute survives to this day as the symbol of the modern medical profession. [2] Interestingly enough, his daughter Hygiea was influential as well. She inspired the word hygienic. [1]

At approximately the same period in ancient Greek history, Hippocrates was practicing. He later became known as the "Father of Medicine," inspiring more than 50 written works. He advised doctors on how to rationally examine patients for symptoms to provide simple treatments, and to observe and record the development of diseases. [1] Enter the patient medical record.

Asclepius and Hippocrates represented the two sides of the Greek medical tradition. The followers of Asclepius believed in supernatural causes and cures for disease. Conversely, followers of Hippocrates believed that disease had natural causes and that it could be treated and cured by rational methods. Religious practices and rational explanations to treat illness existed concurrently as the ancient Greeks combined scientific approaches with supernatural beliefs.[1] This is not unlike some patients today, who combine modern medicine with alternative practices.

As Hippocrates kept looking beyond the supernatural, medicine came to be seen as a science rather than a religion. He stressed the importance of observation, diagnosis, and treatment. Retrospectively, Hippocrates' ideas were a strange mixture of common sense and inaccuracy. His suggestions about diet and exercise are as valid today as they were 2,400 years ago; however, his belief in the Four Humours was completely wrong. Interestingly enough, the Four Humours theory lasted until the 17th century, but the importance of exercise and diet was long forgotten. [1]

Beyond his revolutionary theories of medicine, Hippocrates' most important contribution was the development of a professional code of conduct, specifically for physicians. His students had to follow a strict ethical code that governed their behavior. The original oath was a specific effort to place physicians on a "higher footing than other healers." [1] Thus, the long tradition of holding physicians to high standards began and perhaps the birth of medical ethics.

Where are we now?

Although less common, physicians today can still choose to swear an oath. Modern oaths continue to be used, but vary. Individual content has been adjusted and reflects fewer of the original components. According to a 1993 survey of 150 medical schools, only 14 percent of modern oaths prohibit euthanasia; 11 percent hold covenant with a deity; 8 percent foreswear abortion; and a mere 3 percent forbid sexual contact with patients. All of these were included in the original version. The original even calls for free tuition for medical students – something that would make all current medical students green with envy. Furthermore, doctors were never to "use the knife," that is, conduct surgical procedures. And maybe most interestingly, fewer than half of modern oaths address consequences for not keeping the oath. [3]

As a growing number of physicians feel that the original Hippocratic Oath is antiquated and inadequate to address the current realities of the medical world, some have questioned the oath's relevance. For example, should physicians of different specialties swear to a single oath? [3] Although originally objected to, specialization eventually became accepted within America in the mid-19th century. People who objected to specialization said that "specialties operated unfairly toward the general practitioner, implying that he is incompetent to properly treat certain classes of diseases" and that specialization tended "to degrade the general practitioner in the view of the public." However, as the base of medical knowledge continued to grow and many doctors chose to do more of what they were particularly interested in and good at, specialization emerged. [4] Specialization itself may bring additional ethical considerations.

Furthermore, some physicians claim that the principles sworn to in the original oath never contained a shared core of moral values because of the oath's pagan origins. This pagan influence may make it incompatible with beliefs held by Christians, Jews, and Muslims. [3] Lest one assume modern medicine has completely separated itself from "religion," there exist medical codes of ethics for individual, current religions. For example, the Islamic Code of Medical Ethics (http://www.islamset.com/ethics/code/ medprf.html) states "'Medicine', is a religious necessity for society." [5] Others note that the original oath makes no mention of modern issues, such as the ethics of experimentation, team care, or a doctor's societal or legal responsibilities.[3] Obviously all are issues that continue to challenge the modern practicing physician.

The oath-taking tradition is currently seen by some as having little to no value. "The original oath is redolent of a covenant, a solemn and binding treaty," writes Dr. David Graham in *JAMA* (12/13/00). "By contrast, many modern oaths have a bland, generalized air of 'best wishes' about them, being near-meaningless formalities devoid of any influence on how medicine is truly practiced." Some physicians claim what they call the "Hippocratic Oath" should be radically modified or abandoned altogether. [3]

Medical practice in the United States

At the beginning of the 17th century, medical practice in England was divided into three distinct groups: the physicians, the surgeons, and the apothecaries. Physicians were viewed as the elite and usually held university degrees while surgeons were apprenticed. Surgeons often served the dual role of barber-surgeon. Apothecaries also learned their roles prescribing, making, and selling medicines, through apprenticeships and sometimes within hospitals. [4]

This distinction between medicine, surgery, and pharmacy did not survive in colonial America. University-prepared MDs from England, upon their arrival in America, were expected to also perform surgery and prepare medicines. [4]

In July 1766, The New Jersey Medical Society was chartered. It was the first organization of medical professionals in the colonies and was developed to "form a program embracing all the matters of highest concern to the profession: regulation of practice; educational standards for apprentices; fee schedules; and a code of ethics." It remains the oldest medical society in the United States. [4]

In May 1846, a national convention was held to address numerous abuses within medical education. Proposals from that convention included the creation of a national medical association, the adoption of uniform higher educational standards for MDs, including suitable courses of premedical education, and a standard code of ethics for the profession.[4] The following year, a variety of delegates convened and resolved themselves into the first session of the American Medical Association (AMA). The AMA has set and continues to revise educational standards for the profession, among other things. [4]

Medicine was the first profession to require licensure. State laws specific to the licensure of medicine outlined the activities

of "diagnosis" and "treatment" of human conditions strictly within the domain of medicine. Any individual who professed to "diagnose" and/or "treat" as part of his/ her profession could therefore be charged with "practicing medicine without a license." [4] This remains so, as the Texas Constitution gives the legislature authority to pass laws prescribing the qualifications for those practicing medicine and to punish persons for malpractice.

The Medical Practice Act regulates the granting of the privilege to practice medicine in Texas. It defines "practicing medicine" as "the diagnoses, treatment, or offer to treat any disease or disorder, mental or physical, or any physical deformity or injury by any system or method or the attempt to effect cures of those conditions by a person who publicly professes to be a physician or surgeon; or directly or indirectly charges money or other compensation for those services." [6] With the inception of telemedicine, there has been concern about how to handle state licensure issues when medicine is being shared between states through telecommunications. Laws and guidelines are being addressed. [4]

Medical ethics defined

Medical ethics is the discipline of evaluating the merits, risks, and social concerns of activities in the field of medicine. It shares many principles with other branches of health care ethics, such as nursing ethics. Principles have been suggested to help evaluate the ethics of a situation. To begin with, a practitioner should act in the best interest of the patient. This is called beneficence, or *Salus aegroti suprema lex.* Secondly, the physician should "first, do no harm," or *primum non nocer*. This is called non-maleficence and has origins in the original Hippocratic Oath. Autonomy, or *Voluntas aegroti suprema lex*, is the principle that the patient has the right to refuse or choose their treatment. The principle of justice concerns the distribution of scarce health resources, and the decision of who gets what treatment. Next, the patient (and the person treating the patient) has the right to dignity. Lastly, the patient should not be lied to and deserves to know the whole truth about his or her illness and treatment (though certain exceptions are made for the proper use of placebos).This principle is truthfulness and honesty. [7]

However, as Oscar Wilde said, "the truth is rarely pure and never simple." [8] Therefore, principles such as these do not address how to handle a particular situation, but guide doctors on what principles ought to apply to actual circumstances. The principles sometimes contradict each other leading to ethical dilemmas. For example, the principles of autonomy and beneficence clash when a patient refuses a life-saving blood transfusion. [9]

AMA principles of medical ethics

- A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements that are contrary to the best interests of the patient.
- A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- 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 care.
- A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- A physician shall support access to medical care for all people. [10]

Scenarios — what would you do?

Considering the principles of ethics adopted by AMA and your own ethical commitments, evaluate what you would do in each of the following situations.

To terminate or not to terminate

You are a practicing obstetrics physician in a large metropolitan area. You delivered a baby for a patient three years ago. She is pregnant with her second child and has come to your office for her initial pregnancy exam. During the exam, you remember that she has a large outstanding balance from her first delivery. You finish the exam without addressing your financial concerns to the patient. Later, you discuss the issue with your office manager, who says she happens to know that this patient is capable of paying for the services rendered. You resent providing free care for this patient.

To test or not to test

You are a practicing pediatrician with a long-term relationship with Susie and her mother. The mother brings in this 14-year-old girl for her yearly physical. When Susie goes to the bathroom to provide a urine sample, the mother whispers to you that she would like you to secretly perform a drug test on Susie. The mother makes compelling arguments for doing so, indicating that Susie has had mood swings, inconsistent behavior, dropping grades in school, and has been involved recently with "the wrong crowd."

To forgive or not to forgive

You are a general surgeon who performed an open abdominal surgery on your patient, a married young mother of two small children, six months prior. Although the surgery was indicated and you did not violate the standard of care, she had less than optimal results. She developed an infection, was hospitalized longer than expected, and suffered unanticipated pain. The primary floor nurse was observed being less than nurturing to this patient, and she was the unfortunate recipient of a minor medication mistake. Because of the unanticipated length of hospitalization due to the infection and medication error, she incurred the additional personal expenses of flying in her mom from California to assist in the care of her children. Her husband did the best he could, however was not able to take off much time from his job as a mechanic. Because you review all records of patients being sent to collections, you recognize this patient's name on the list.

To report or not to report

You are a family physician in a rural community. Your clinic is the primary source of health care for the community and you employ several mid-level practitioners and other physicians. Johnny arrives today for his well-child check. You have been treating this family for years, and he is the newest member. As you review the chart, you notice that Johnny has been treated at your office 10 times in the past two weeks. These visits have been for an initial well-baby check, an injury to his penis and other irregular injuries, colic, and general fussiness. He has seen a variety of providers, from mid-level practitioners to physician colleagues. The mom has reported

that she has separated from the birth father and has been living with a new boyfriend since Johnny's birth. Five other children live in the home. The mom tells you she "can't make it" without the new live-in boyfriend. Ultimately, the child's injuries are suspicious. You suspect the boyfriend of abuse.

To call DPS or not to call

You are an internal medicine physician practicing in a rural community. An elderly woman and her husband have been your patients for 20 years. The husband is completely dependent on the wife for all activities of daily life including grocery shopping and transportation to your office. Recently, the wife suffered an epileptic seizure and is advised not to drive.

An analysis framework

The AMA states, "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self." [10]

As one attempts to navigate ethically challenging situations, the following framework, adapted from *Access Excellence,* [11] may be helpful. To begin with, gather all available factual information. Obviously this is easier said than done. First, it is always a challenge to take time out of a busy physician schedule. If that isn't challenging enough, even the latest information may be wrong a short time later. For example, journals may publish an article one week describing the findings of a group of scientists, and publish another the next week by a different group contradicting the first. They looked at similar data and have drawn different conclusions, illustrating that even experts disagree. Taking time out to gather and appropriately analyze critical factual information related to an ethical dilemma will be tough initially, but ensure you make the best decision possible in the end.

Secondly, consider beliefs and values. At this point, one may address his or her own beliefs and values. People are often ready to die for what they believe in. For example, Jehovah's Witnesses believe that death is preferable to accepting blood products and consciously betraying their convictions. As a physician, one may have beliefs and values you feel particularly strong about as well. Examining our own convictions is an ongoing challenge, but essential in sound ethical decision-making, as your beliefs and values may be in conflict with patient beliefs and values.

Next, applicable rational principles need a thorough review. According to the author, this includes the principle of beneficence, which was a largely "hit and miss" affair in the past. It was the predominant principle in early medicine because medicine could not consistently do only good things. Even today, all treatment involves inherent risks. The example given in this model involves a male runner undergoing arthroscopic knee surgery. Three days later, he developed an embolism, had a massive stroke, and eventually died. Although this example is a perfect one to illustrate the uncertainty of medicine, readers can reflect on their own experiences with unanticipated outcomes. Fortunately, or unfortunately, this is an issue with which physicians will continue to struggle. Am I doing no harm?

The author goes on to illustrate the principle of autonomy in genetic testing. Obviously, the adult patient's autonomy is reflected in his or her choice to be tested or not. However, many patients under the age of 18 are capable of making the decision for themselves. If the parent of a 17-year-old decides to have the child tested without informing the child, you have a non-autonomous subject, actually capable of understanding the medical decisions being made on his or her behalf. Autonomy often conflicts with justice. For example, should a government pay for screening programs from which the economic benefit derived from prevention does not outweigh the cost of screening? Individuals may want the testing done, but does that obligate society to pay for it?

Justice, as a principle in medical ethics, is understood to be determining fair allocation of finite resources. Obviously, this principle is cause for concern only when resources become scarce. The author uses dialysis as an example. The patient may have access or not, depending on the diagnosis per Medicare reimbursement. A similar example could easily be taken from managed care. Physicians may feel as though they can practice only the medicine that will be reimbursed.

Lastly, the author addresses external and extrinsic factors, including economic, regulatory, legal, and the media. Physicians face ongoing economic factors in practice — billing, patient's inability to pay, keeping your doors open. Certainly, regulatory issues factor in as well — HIPAA, CLIA, OSHA, just to name a few. The media's exaggeration of both harms and benefits, recent scientific breakthroughs and perceived failures may make the very discerning patient and practitioner leery.

Arrival at any kind of institutional policy or even personal conclusion requires careful consideration of these principles. To help aid in specific decision-making, risk management considerations are offered.

Risk management considerations

As explained in a previous issue of *the Reporter* by Barbara Rose, terminating the physician-patient relationship has remained a hot topic in risk management for years. Both physician and patient have the right to terminate the relationship; however, the playing field is certainly not level. A process of proper documentation and adequate notice giving is recommended to avoid potential civil liability related to abandonment. To muddy the waters, the medical-legal literature does not clearly define what constitutes proper documentation and suitable notification.

When appropriate, the physician should orally advise the patient of the decision to terminate and document this action in the medical record. For each terminated patient, send a letter by U.S. mail and a certified letter, return receipt requested. In this letter, explain that you will see the patient for an additional 30 days, after which time the patient should have chosen another physician. With the letters, enclose a HIPAA-compliant authorization to disclose information. The patient should be advised to select a new physician as soon as possible, and return the authorization indicating the physician of choice. At that point, office staff will copy and forward the patient's medical record to the newly designated physician. Place copies of these letters in the patient medical record.

Generally, once established, the physician-patient relationship continues as long as medical treatment is required, unless the physician or patient ends it. Deciding to end a patient relationship requires consideration of the patient's medical status and needs. In our scenario, for example, the pregnant patient was never terminated. Although she did not require obstetrical care between children, she was never actually terminated from the practice. Because of her payment history, or lack of, the physician must balance the desire to care for the patient with the ability to do so without reimbursement.

Generally speaking, terminating a relationship with a pregnant patient sooner instead of later is preferable. Regardless, you may eventually be named as the physician of record, and be asked to deliver the baby. Therefore, it is recommended that the physician continually evaluate the ability to provide care without reimbursement for those patients delinquent in their accounts. Perhaps if the physician in this example

had done this, he or she would have been able to terminate before the patient's initial exam for the second pregnancy. [12]

Drug testing a capable minor patient without his or her knowledge may create a tension between patient autonomy and legality. You may indeed be legally able to test a minor patient upon the parent's request; however, would this violate your physician-patient relationship? Choices in this situation may include complying with the parent's request, refusing the parent's request, or encouraging and facilitating dialogue between parent and child. Although the last option may take more time, it may prove the choice that allows you to honor both the trust of your minor patient and the parent's wishes. Ultimately, the physician is the only person who, after gathering all possible factual information, can make this difficult decision.

Forgiving or writing off patient medical debt is something commonly done. Many physicians provide a great deal of medical care without patient or insurance reimbursement. They may do this for a variety of reasons: commitment to access to care for all patients; continuing to follow a long-term patient through a financially difficult time; or patient dissatisfaction with care provided. Physicians may not choose to forgive patient medical debts for equally compelling reasons: the physician cannot afford to financially maintain the practice by doing so; the physician has a policy to charge each person consistently, regardless of the situation; or the physician feels as though forgiving a debt may admit guilt in the event of an unanticipated, adverse outcome.

When deciding to forgive a debt or not, it is important to have all of the factual information. For example, the patient may be withholding payment because of anger with you or your staff. Regular review of your aged receivables report will allow you to keep track of those with outstanding balances. A forum through which patients may express an opinion regarding your services may also identify those who are unhappy. Furthermore, your practice may choose to develop a policy regarding collections. Ultimately, physicians must make those decisions after carefully weighing all facts, and after careful consideration regarding their practice policy.

Family violence is defined as "abuse by a member of a family or household of a child by physical injury, threat of physical injury, harmful sexual conduct, or compelling or encouraging the child to engage in sexual conduct." The medical professional that comes to believe that a child has been abused or neglected must personally report it within 48 hours. The medical profession may not rely on a delegate to make the report. Reports must be made to one of the following agencies: the Department of Family and Protective Services, http://www.dfps.state.tx.us/(previously known as the Texas Department of Protective and Regulatory Services); local law enforcement; or the agency designated by the court to be responsible for protecting children. Other agencies may apply in very specific circumstances. [13] Fortunately, or unfortunately, the external principle of the legal requirement to report child abuse supercedes other principles in ethical decision-making. Please use TMLT Risk Management phone consultation as needed.

Other legal requirements are not as concrete. According to the Texas Statutes Health & Safety Code, Chapter 12: Powers and Duties of Texas Department of Health, a physician may inform the Department of Public Safety of patients whom the physician has diagnosed with disorders or disabilities outlined as potentially impairing the patient's ability to drive.[14] Therefore, the physician whose patients have been diagnosed with epileptic seizure disorders, cognitive changes, visual impairments, or other such disorders will have to analyze each specific situation independently. The decision to report or not should be based on ethical decision-making principles, weighing all factors unique to the situation. Does the patient's right to autonomy outweigh the potential risk to others?

Conclusion

Since ancient Greek society, physicians have exhibited high professional standards. The Hippocratic Oath, although controversial and currently altered significantly, continues to pervade the American medical community reflecting the modern physician's commitment to excellence in practice. This commitment, at times, may create challenges for practicing physicians when the "right" choice is not necessarily obvious. Legitimate ethical principles may be at tension with one another, obligating the physician to analyze each situation independently. Careful analysis, using ethical principles, may aid the physician in making sound decisions that reflect commitment to the patient, as well as the medical community and society at large.

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EXPIRED CME

CME test questions

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

Using one of the scenarios from the article, answer the following questions. (Please print legibly.)

1. What factual information can be identified?

2. What principles may be at tension with one another?

3. What would you do and why?

CME evaluation form

Please complete the following regarding the article, "From Hippocrates to the AMA."

1. The objectives for this CME were met. ☐ Yes ☐ No

2. The material will be useful in my practice. ☐ Yes ☐ No

3. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain. ☐ Yes ☐ No

4. How long did it take you to complete this learning activity? ☐ 0.5 hr ☐ 0.75 hr ☐ 1 hr ☐ 1.25 hrs

5. On a scale of 1 to 5, with 5 being the highest, how do you rank the effectiveness of this activity as it pertains to your practice? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

6. What will you do differently in your medical practice after reading this article?

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7. Suggestions for course improvement are:

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closed claim study

Failure to treat symptoms of coronary artery disease

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

A 40-year-old man came to a family physician with a chief complaint of an earache. The patient reported that he smoked, and had a family history of heart disease (both parents) and hypertension (sibling and mother). At this visit, the patient's blood pressure was elevated and labwork indicated high cholesterol. An EKG was interpreted as normal.

Physician action

The patient was given Ziac for his blood pressure and medication for the earache. The family physician also recommended a low-fat diet and regular exercise.

Over the next 5 years, the family physician and his nurse practitioner saw the patient for routine complaints and treated his hypertension and high cholesterol. The Ziac was continued and Zocor was added to control the patient's cholesterol. The medical records from these visits indicate that the patient was not completely compliant with the recommendations to exercise and follow a low-fat diet. The patient continued to smoke and have high cholesterol.

Approximately six years after his initial visit, the patient came to the office complaining of "heartburn when runs," and to obtain prescription refills. The patient was seen by the nurse practitioner, who noted in the record the complaint of "When running, gets acid burning in chest." The NP indicated that she always checks the patient's heart, lungs, and abdomen with a stethoscope and only notes abnormalities. There were no notations for this exam. The patient's blood pressure was 140/100 mm Hg. The nurse practitioner diagnosed GERD and recommended a GI study. The office note for this visit was not countersigned by the family physician. The physician does not remember if he and the nurse practitioner discussed this visit, although it is his practice to do so.

Five days later, the patient reported to a diagnostic center for an upper GI. The results were interpreted as hiatal hernia with no evidence of reflux at the gastroesophageal junction.

The patient returned to the family physician's office one month after the upper GI. The nurse practitioner discussed the upper GI results with the patient, and diagnosed hypertension, hiatal hernia, and occasional reflux when running. The nurse practitioner prescribed Nexium before running and increased the dosage of Ziac. The patient was advised to return as needed. The written exam findings were minimal, but the nurse practitioner did say that she checked the patient's heart, lungs, and abdomen. As with the previous office visit, the office note was not countersigned by the physician. The physician did not recall if he discussed this visit with the nurse practitioner.

Approximately one month later, the patient suffered a myocardial infarction and died at the age of 46. In the autopsy report, the pathologist said the patient died as a result of severe coronary atherosclerosis. A 90% narrowing on the descending branch of the left coronary artery, a 30% narrowing of the circumflex branch of the left coronary artery and a 20% narrowing of the right coronary artery was found. There was also evidence of a previous MI.

Allegations

A lawsuit was filed against the family physician and the nurse practitioner. The allegations included:

- failure to treat the patient for a persistent complaint, including signs and symptoms of coronary artery disease;
- failure to order diagnostic tests to determine the cause of the patient's complaints;
- failure to refer the patient for cardiac evaluation; and
- failure to supervise the nurse practitioner.

Legal implications

The plaintiff's expert testified that the family physician failed to meet the standard of care because the patient's "BP and blood lipids were inadequately controlled, aspirin was not prescribed, and the symptom of chest burning was unrecognized as a manifestation of coronary artery disease." Further, the expert stated the patient should have been sent for a cardiac work-up before being sent for a gastrointestinal evaluation.

The allegations regarding failure to supervise the nurse practitioner were based on the medical records from visits in which the patient was seen solely by the nurse practitioner. The records from these visits were not counter-signed by the physician, and there was no documentation that the nurse practitioner and the physician conferred about the patient's new symptom of "heartburn when runs."

Defense family physician consultants were not entirely supportive of the care provided by the defendants. It was the opinion of one consultant that exercise-induced chest symptoms in a man with a family history of coronary artery disease, poorly controlled hypertension and hyperlipidemia, and a history of tobacco use is

ischemic cardiac disease until proven otherwise. One expert stated that it is not uncommon for a patient to self-diagnose heartburn even when the symptoms are suggestive of coronary ischemia. Practitioners can sort this out by asking questions to support the diagnosis of cardiac versus GI symptoms. Consultants described the care rendered as significantly weak due to the defendants missing the diagnosis of new onset angina. They were also critical of this physician for not properly supervising the nurse practitioner.

Patient noncompliance became an issue in this case. A review of pharmacy records indicated the patient did not take his Zocor regularly — for a period of as much as 9 months at a time. The patient also did not follow-up as scheduled with the family physician, often only returning for prescription refills. The patient's wife testified that after her husband's last office visit he reported that the medications did not alleviate the burning sensation. She encouraged her husband to contact the physician, but does not know if he did so.

Disposition

Because the main allegations in this case involved the actions of the nurse practitioner, the court was asked to dismiss the physician from this suit. This request was denied by the judge who stated that a physician is fully responsible for the actions of his or her nurse practitioner.

This case was settled on behalf of the family physician and the nurse practitioner. The incomplete documentation and the inability to obtain supportive defense consults led to the decision to settle this case.

Risk management considerations

A complete, comprehensive medical record not only provides a chronological history of patient care, but it may become the foundation for defending the physician and his or her staff if a lawsuit is filed. If a nurse practitioner routinely examines the patient but only documents the presence of abnormal findings, the record sends the message that the patient was not thoroughly examined. The documentation of each visit needs to accurately reflect what occurred.

Complete documentation can also help physicians and mid-level practitioners know which patients they discussed. When relevant, the notes of the nurse practitioner are expected to include a notation that the patient's condition was discussed and that the physician concurs with or alters the plan of care.

When physicians employ mid-level practitioners, they assume responsibility for the actions of these staff members. It is the responsibility of the employer to develop a comprehensive job description and written protocols describing the delegation of duties for mid-level practitioners. Documentation guidelines and when to consult with the physician should be well defined. To document events accurately a physician can develop a protocol to review and co-sign the notes, indicating that a consultation occurred and that the notes are correct.

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In case you missed it . . .

CMS to offer EHR system

In a move to promote the adoption of electronic health records, the Centers for Medicare and Medicaid Services announced a giveaway to American physicians: free EHR software based on the system developed and used by the Veteran's Health Administration for 20 years.

The original software program, VistA (Veterans Health Information Systems and Technology Architecture) was modified for physician office use and renamed VistA Office EHR (VOE). It is intended to be a low-cost EHR alternative to commercially available systems. VOE's release was scheduled for August 1, but it has been delayed. When released, the software will be available through http://www.vista-office.com/.

This initiative is unique in that the VOE software is in the public domain and there is no software "vendor" in the traditional sense. The Iowa Foundation for Medical Care (IFMC), Daou Systems Inc. and WorldVistA are providing distribution, development, and vendor support for VOE.

Although implementation of VOE in the office can be done independently, only very limited technical support will be provided at the VOE web site. Users with detailed support needs will be redirected to a list of vendors.

While VOE software is free to any physician, costs associated with installing and using the system could reach $10,000 to $12,000, according to the American Academy of Family Physicians. These costs include training, implementation, customization, technical support, and other software and operating system requirements. Physicians may also have to purchase billing or practice management software that interfaces with VOE. This cost estimate does not include the hardware, such as the computers and network upon which the VOE will run.

For more information, please visit the following web sites:

- www.cms.hhs.gov/quality/pfqi.asp
- www.vista-office.com
- ww.worldvista.org/vvso/
- www.ifmc.org/

rate reductions. . . *continued from page 3*

"Policyholders now have even more opportunities to reduce their premiums by participating in loss prevention and by maintaining good loss ratios," says Cotten.

Service charge eliminated

TMLT will no longer assess a service charge to those policyholders who pay their premium in installments.

New service charges will be discontinued effective January 1, 2006 for new business and renewals. Policies already in effect on that date will have their outstanding service charges included on the remaining invoices for that policy term, but these charges will be discontinued when the policy renews.

"The current rate decreases and other benefits we are passing on to policyholders are gratifying, particularly because it affirms the impact of medical liability reform," says Cotten. "It is wonderful to be able to give something back to the physicians."