Health care reform and physician employment

by Douglas M. Kennedy

Changing practice patterns

Recent health care reform legislation — the Patient Protection and Accountable Care Act (PPACA) — resulted in a congressional initiative to develop a system to improve the quality of medical care and reduce health care costs. The primary mechanism for achieving these goals is a concept called the Accountable Care Organization (ACO). The details about how ACOs are to be structured and governed and how they will overlap with existing patterns of practice has not been fully developed. In all of the conceptual discussions, there is the assumption that traditional patterns of medical practice and reimbursement will change to accomplish the desired efficiencies. One expected result will be a shift in physician practice patterns from private practice into employment with larger health care organizations.

Even before the recent legislation, the traditional delivery of medical care has been changing, with a steady growth of multi-specialty, multi-location medical practices. A desire to increase the availability of physicians in chronically underserved areas, as well as a need for nonprofit hospitals to attract and employ highly specialized professionals, has resulted in the development of specialized entities. One of these entities is the certified nonprofit health organization (NPHO). Further, there has been an increase in the number of physicians who elect to forego private practice and seek employment with these entities.

In an April 2010 Texas Medical Association (TMA) survey of physician employment, preliminary findings indicate that since the early 1980s there has been a continuing decline in the number of new physicians who start their practice as an owner of a solo or group practice. Although a majority of physicians are currently private practice owners (71%), more than half of physicians begin their careers as employees. Of those who remain in an employed or contract environment, a significant percentage of them are employed with an NPHO (28%).

Factors that cause physicians to seek employee status include the desire for work-life balance; the prospect of a guaranteed income; the inability to finance and/or capitalize a practice; the increasing administrative demands of a private practice; and the technological advantages available when practicing in a larger practice group. Among those who have left an employment situation, the overwhelming reason is a desire to maintain personal control over clinical decisions. Other factors include the ability to control the geographic location of the practice and to determine opportunities for practice growth.

With the advent of ACOs, several large health care systems and providers have announced plans to develop an ACO. Christus Health, Baylor Health System in Dallas, and Memorial Houston Health Care Center are among those organizations.

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This article will describe the two entities — the NPHO and the proposed ACO — and discuss the affect the formation of these entities will have on employed physicians. This will be followed by a discussion of issues that physicians must address when considering employment with either of these organizations. These issues include increased liability and licensing risk and the additional restrictions on individual practice decisions that could occur to achieve cost containment and uniform practice standards.

In Texas, the conceptual framework for an ACO must be balanced against the state’s policy prohibiting the corporate practice of medicine. The structure of the NPHO already reflects the underlying prohibition of the corporate practice of medicine. The statutory provisions — which result in the prohibition of the corporate practice of medicine — may be found in Texas Occupations Code. 1 These include Sections 155.001 (a person may not practice medicine in the state of Texas without a license); Section155.003 (eligibility requirements for a license); and Section164.052 (a physician is prohibited from permitting another to use that person’s license or to practice medicine or from directly or indirectly aiding the practice of medicine by an unlicensed person, partnership, association, or corporation).

Further, the development of ACOs, which requires collaboration with medical care professionals, may mandate changes in current federal or state fraud and abuse laws. This includes provisions that prohibit kickbacks, self-referrals, physician incentive payments, and changes in anti-trust regulations. The PPACA provides for the potential waiver of some of these regulatory provisions for ACOs implemented under the act, but the waiver provision would not apply for ACOs not implemented under the act.

**Introduction and history: NPHOs**

NPHOs that are certified to employ physicians have long been referred to as “5.01a” corporations. This designation refers to the former section of the Medical Practice Act. 2 NPHOs are created according to the Texas Business Organization Code. 3 However, despite the Texas prohibition of the corporate practice of medicine, a nonprofit corporation can be certified by the Texas Medical Board (TMB) to employ physicians. 4 This special exception was enacted by the Texas Legislature to permit nonprofit health care related entities to recruit and retain physicians to provide care in chronically underserved areas and populations, and to allow these organizations to achieve their charitable and educational goals.

The TMB originally certified a health organization to employ physicians if it met certain requirements, including that:

1) it must be a nonprofit corporation;

2) its purposes must meet some or all of the criteria set forth in the statute, including improving and developing the capabilities of individuals and institutions studying, teaching, and practicing medicine and delivering health care to the public; 5

3) it must be organized and incorporated solely by licensed physicians actively engaged in the practice of medicine; and

4) the organization’s board of directors must comprise licensed physicians actively engaged in the practice of medicine.

Over time, nonprofit hospital corporations began financially supporting the development of affiliated certified nonprofit health organizations to recruit and employ the physicians. This was necessary to support the corporation’s educational goals and to achieve their goal of providing health care to the public. These nonprofit hospital corporations were the sole “members” in these NPHOs 6 In the late 80s and early 90s, issues arose concerning the necessity of the “member” nonprofit hospital to exercise financial control over an affiliated nonprofit to maintain their tax exempt status.

At the same time, the TMB remained concerned about what controls a non-physician “member” could exercise over an NPHO that was certified to employ physicians. As a result, the TMB created new rules that required the NPHO to:

1) reserve the sole authority to engage in the practice of medicine to its retained physicians and the sole authority to direct the medical, professional, and ethical aspects of the practice of medicine to its board of directors (physicians) 7 ;

2) ensure that the termination of any physician may only be accomplished through the physician board 8 ; and

3) reserve to the member (hospital) seeking to obtain or maintain tax exempt status, the right to make financial decisions including decisions relating to the capital and operating budgets, physician compensation, and decisions concerning managed care contracts. 9

Therefore, this special hybrid allows a nonprofit hospital to financially support and oversee an NPHO that employs physicians. It also ensures that the direction and delivery of medical care rests solely with the licensed physicians and a physician board of directors.

Since 1972 — the year after the TMB (Texas Board of Medical Examiners at the time) began certifying nonprofit organizations — 647 organizations have been certified and of those, 341 have been de-certified. The vast majority of certifications have occurred after 1993 with most de-certifications occurring after 2000. Today, there are 306 nonprofit organizations certified to employ physicians in Texas.

**Introduction and history: ACOs**

ACOs consist of a network of physicians, hospitals, and other providers that collaborate to improve the quality of health care services and reduce costs. The concept of an ACO is attributed to Dr. Elliot Fisher of Dartmouth Medical School. Dr. Fisher led the Dartmouth Atlas Project, a 30-year project documenting the variation in care and costs of care across the United States. Dr. Fisher envisions replacing the current payment system that rewards volume and intensity of service rather than quality and cost performance.
In pilot projects being developed for ACOs, participants in the ACO would participate in a shared savings program involving Medicare beneficiaries. Under such programs, the ACO and a payor would establish a benchmark for a total expected annual savings. The participating physicians and organizations, if they meet established quality and performance levels, would be given a bonus if cost savings were realized for the ACO. The allocation of this bonus payment among the participants would be negotiated in advance.

One barrier to the integration of the different health care professionals into the ACO is the differing ways that physicians and business executives operate. Physicians, because they have ethical and practice standards to maintain, view the delivery of care from one perspective. Health care business executives may approach the delivery of health care more from a financial perspective. Although they both approach delivery of medical care with the best interest of the patient in mind, the two groups do not always agree.

For more detailed discussions of ACOs, please see the following articles.

- The historical development of the ACO is summarized in a Seton Hall article. This article compares the strengths and weaknesses of various payment reform models, including ACOs, and explains that the ACO requires a legal organization that can receive shared savings, the capability to incorporate primary physicians who solely practice under the ACO, and at least 5,000 beneficiaries to make it viable. An article in the Journal of Health and Life Sciences offers an overview of legal hurdles that must be addressed with the ACO.

- The CMS Office of Legislation has provided answers to common questions about shared savings program. These answers include that a beneficiary may seek services from a provider outside the ACO and that participating ACOs will not be subject to payment penalties if benchmark targets are not achieved.

- Other analyses of the proposed structure of ACOs include a detailed analysis by the American Hospital Association; several articles reflecting the preliminary analyses of ACOs published in Texas Medicine, as well as a separate overview of the ACO by the TMA; and an article from Texas Hospitals that includes Texas Hospital Association (THA) recommendations.

The THA recommends that ACOs should be allowed to enter into business or compensation arrangements with participating providers without the fear of violating the prohibition against the corporate practice of medicine, anti-kickback provisions, or fee splitting prohibitions. As noted earlier, the PPACA already authorizes the Secretary of HHS to waive anti-kickback and self-referral provisions to enhance the potential for successful ACOs. However, the THA also recommends that ACOs should adopt policies and procedures to ensure that physicians retain the authority to exercise independent medical judgment. If payments are accepted on a capitation basis, THA believes that ACOs should be licensed as insurers. To extend the provisions of medical liability reform, THA recommends that ACOs should be defined as health care providers under professional liability statutes.

Robert Hendler, Vice President of Clinical Quality and Regional Medical Officer for Tenet Health Care Corporation in Dallas, believes that the switch to an ACO will shift the emphasis away from volume and ultimately reward providers who achieve better results at lower costs. “Under health care reform, the government plans to move income from physicians defined as low quality, low efficiency providers to high quality, high efficiency providers by using a value based modifier for payment.”

An overview of ACOs published in Texas Medicine describes an example of an ACO payment methodology, stating “for physicians, a fundamental issue will be how to share the savings if physicians are not leading the initiative. Hospital-led ACOs will have an incentive to capture physician services via employment contracts or withholds, leaving all profit for the hospital and none to the physicians.” In 2009, efforts were made in the Texas Legislature to implement the ACO model into the Medicaid bill. This effort will likely be repeated during the 2011 session. The underlying message from the Texas Medicine article is that it is in the physician’s best interest to study the structure and proceed to a leadership position in the creation of the ACO.

Scott & White Healthcare Center has been described as a truly integrated health delivery system that meets all the criteria for an ACO. It has a virtual monopoly for the delivery of health care in its primary region around Temple. In a recent study of Medicare expenditure data from 1992 to 2006, Scott & White performed well. Expenditures for enrollees in Temple were one-third less than expenditures for enrollees in Dallas. Of all the teaching hospitals studied nationwide, Scott & White spent the least amount of money on end of life care.

The study reports that most of Scott & White’s physicians earn only about 80% of the national average, but they are willing to take a pay cut because they believe they are able to practice good medicine without the pressures of business. It was conceded that physicians also give up some personal autonomy. The effort to produce quality care includes evidence-based protocols and physician report cards. Though this study is limited, it provides an interesting look at how an ACO might work.

The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association have issued joint statements describing principles that these groups believe must be met to establish physician support of ACOs. These principles include:

- The ACO should demonstrate strong leadership from physicians and other health care professionals in its administrative structure, policy development, and decision-making policies.
• The ACO should include processes for patient and family input and should provide incentives for patient or family engagement in their own health and wellness.
• Participation by physicians and patients in the ACO should be voluntary.
• Measurements of performance and efficiency in an ACO should be based upon nationally acceptable, reliable, and validated clinical measures.
• Physicians should have the option to participate in multiple ACOs.
• Barriers to small practice within the ACO should be addressed and eliminated.
• ACOs should be adequately protected from existing anti-trust, gain sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
• ACOs should promote processes to reduce administrative complexities.
• Payment models and incentives should adequately reflect the relative contributions of participating physicians and other health care professionals.
• Rewards for performance should be based upon processes that include achievement relative to set target levels of performance, achievement relative to other participants, and improvements that have been developed with significant input from physicians and other health care professionals.
• The structure of the ACO should adequately protect ACO physicians from insurance risk, unless clearly agreed to as a requirement for participation.
• ACOs should employ a variety of payment approaches including, but not limited to, blended fee-for-service, prospected payment, shared savings, and partial capitation.

Issues to consider before employment

When a physician moves from private practice to employed status, there will be a trade-off between the guaranteed salary and the reduction in the administrative duties versus the loss of control over the time and the methods of practice. A typical physician employment contract will include a scope of employment that details time and call requirements and administrative and educational responsibilities. Free time and vacations will be limited. In a large group, employment may also add another layer of peer review. Compensation arrangements usually consist of salary and bonus based upon revenue or collection milestones plus benefits. There are also provisions that provide for insurance and define the parties’ rights if there is a voluntary or forced end to the employment contract. This can include non-compete provisions.

A comprehensive discussion of standard contract terms and information about pro-physician and pro-employer positions on standard contract terms can be found in the AMA’s “Annotated Model Physician Employment Agreement.”

NPHOs

Physician employment in an NPHO is similar in many respects to employment in any large organization. However, there are some important differences. Generally, if the NPHO is affiliated with a nonprofit hospital, there may be an agreement between the hospital and the NPHO that defines the relationship between those organizations. Many of the provisions in a physician employment contract arise from an agreement between the NPHO and the nonprofit hospital. That agreement may require that physician compensation rates do not exceed reasonable compensation for similar physicians in the area or in national surveys of compensation.

Compensation based upon production or collection formulas may also be affected by the ability of the member hospital to negotiate contracts with payors. Further, the contracts between the hospital and the NPHO may require that NPHO physicians perform administrative and educational duties for the benefit of the hospital. In exchange for these services, there may be an amount that is paid to the NPHO that, when paid, could be an additional source of revenue for the physician.

Many NPHOs — particularly those associated with a nonprofit hospital — may carry medical liability insurance through arrangements involving non-traditional insurance providers. Many of these non-traditional providers were formed before medical liability reform when the cost of insuring large hospital corporations had risen dramatically. In response, hospitals formed captive insurance companies or obtained other alternative forms of risk financing to insure both its risks and those of its affiliated organizations. These types of insurance arrangements may result in different policy provisions, deductibles, and risk management structures. Therefore, special attention should be paid to the insurance provisions before signing the employment contract.

ACOs

If a physician is contemplating employment in an organization that will be structured as an ACO, the physician should be concerned with the actual contract terms and have a working knowledge of the prospective employer’s relationship to the ACO. At this time, there is limited information on how ACOs will be organized and governed. It is anticipated that ACOs may vary widely in their governance, their quality improvement strategies, and how any shared savings will be distributed. To assist physicians in gathering information about these organizations, the TMA is developing an ACO tool kit. Additionally, the TMA has published a paper outlining six important points to consider about Medicare ACOs. The paper highlights the lack of any satisfactory method for resolving significant disagreements within the ACO.

Factors to consider when seeking employment in an organization that will be structured as an ACO include:

• Whether any portion of any salary or bonus is tied to the profitability of the ACO and its ability to achieve cost savings. If so, is there enough information about the other participants in the ACO and the distribution of any savings to form any opinions about the likelihood of a bonus?
• Whether any portion of any salary or bonus is tied to the profitability of the ACO and its ability to achieve cost savings. If so, is there enough information about the other participants in the ACO and the distribution of any savings to form any opinions about the likelihood of a bonus?
• How will quality standards and protocols for integrated care be addressed and eliminated.
treatment be developed? Will they reflect evidence-based medicine and include significant physician input? How will those standards and protocols affect physicians’ medical decisions?

- Is there any additional risk of physician liability that will be encountered by joint participation with other organizations or physicians? Will the physician be protected by the employer’s insurance policy?
- Will the employer organization be able to practice in multiple ACOs? Will patients be free to choose physicians and groups outside the ACO?
- Will peer review information from one organization be shared with other organizations within the ACO or any payors who contract with the ACO?
- Does the ACO have the right to expel a physician? How will that impact the employment relationship with the participating employer?
- Will personal expense items be reimbursed if participation in the ACO requires physicians to travel to the premises of other participating organizations or are physicians required to accommodate the needs of other participants (i.e., auto expense, travel and other personal expenses)?

Personal risk management in an NPHO, ACO, or other group practice

Physicians occupy unique positions in our health care system. The decisions they make affect the life and health of patients, but each decision also places medical licenses and personal financial security at risk. With the continuing trend toward physician employment and the evolution of NPHOs and ACOs, the ability of employed physicians to exercise control over their own risk profile and the ability to make independent medical decisions will become more difficult.

Traditionally, the potential for medical liability for patient care decisions, adverse licensing actions, or sanctions by professional review bodies has been — to some extent — within the control of independent physicians. Physicians have been able to make their own decisions about care alternatives. They can accept to treat or refuse to treat a patient or a group of patients. They can choose which physicians or other health care professionals to collaborate with. The can pick which hospitals to use. Although there are currently some restrictions based on payor networks, physicians can still choose from a wide range of options.

Further, to protect against personal financial risk, physicians have been able to purchase liability insurance through traditional carriers. The type and extent of this coverage is a matter of choice for the physician. Available coverage decisions are affected by market forces that reflect the relative risk encountered. Physicians have been encouraged to make medical decisions that protect the strong prohibition of the corporate practice of medicine. Medical liability reform was enacted to protect both the rights of patients and physicians.

In NPHOs, non-physicians may exercise control over the finances of the organization and physicians may be insured by captive insurance companies or other non-traditional risk financing arrangements. These differences — which affect personal financial risk and physician independence within the group practice — include:

- Lack of traditional insurance provisions that are important to personal risk management, such as the right to consent to settlement, notice provisions for policy cancellation, and tail coverage.
- Variations in risk management programs and claims processing practices.
- Added level of peer review or other professional review actions.
- Required arbitration or mediation for employment disputes or professional review decisions that affect continued employment.
- Inability to select patient population (exposure to more high risk patients).
- Limited ability to choose consultants or ancillary providers.
- Institutional pressures for cost containment and uniform protocols that can affect independent medical decisions.
- Some of these differences can be minimized in NPHOs because they are managed by a physician board of directors. However, this may not be true if the group practice is associated with an ACO.

ACOs as proposed — with their cost containment, quality improvement, and shared savings provisions — have the potential to further alter physician risk and independence. Some of these alterations could include:

- The introduction of more high-risk patient populations.
- Pressure to use mandated protocols based upon evidence-based standards that may be inconsistent with the patients’ desires and the physicians’ determination of the most appropriate care.
- Required referral within the ACO when other providers may offer better treatment alternatives.
- Additional layers of peer review or professional review actions and the potential that failure to meet these quality measures could affect physician employment status.
- The potential for alleged joint responsibility for acts of other providers in other organizations within the ACO.
- Increased financial pressure on practice decisions and utilization of treatment modalities from employers and colleagues to achieve cost containment to earn shared savings bonuses.

Active, engaged physician leadership in the governance of ACOs and targeted legislative or regulatory action can eliminate or reduce some of the personal risks for physicians. However, the uncertainty concerning the actual structure, performance standards, and rules governing ACOs should make physicians cautious when considering employment in such an organization.

Employment in a group practice is a matter of choice and will always involve complex personal decisions for physicians. Whatever practice model is chosen, physicians can make
informed decisions about how to protect themselves and to
preserve their rights to make independent medical judgments.
More specifically, when considering employment in a group
where insurance protection is provided as part of the compensa-
tion arrangement, consider the following:

• Does the group or the physician have the right to consent to
a proposed settlement?
• Are the policy limits consistent with prior coverage and your
individual risk tolerance?
• At the commencement of employment, who provides for and
pays for tail coverage for prior acts?
• At termination of employment, is there a provision for tail
coverage (extended reporting)? Who pays for this coverage?
Will this coverage be available through non-traditional
carriers?
• Who is responsible for paying any deductible?
• Is coverage available for all activities required in the
proposed employment contract?
• Is coverage provided for legal expenses incurred for medical
board proceedings, Medicaid/Medicare audits, or actions by
professional review bodies?
• Review all insurance policies for the NPHO or
ACO to
determine whether the process for claims handling is focused
on the individual physician’s risk potential independent of
other physicians or organizations (including the employer
organization.)

Conclusion

Change is coming — not only in increasing physician employ-
ment — but in the way new health reform models and employ-
ment models will affect physicians. It is essential for physicians
to learn how these changes will affect their practice and their
future opportunities for professional and financial success.

Sources

6. In the Texas Nonprofit Act, members of nonprofit corpo-
rations have extensive rights to control the corporation’s
111-148, Section 1899(a), 124 Stat. 119, to be codified as

11. Cohen JT. Health reform watch, a web log of the Seton
Hall University School of Law, Health Law and Policy
Program. A guide to accountable care organizations and
their role in the senate’s Health Reform Bill.” Available at
http://www.healthreformwatch.com/2010/03/11/a-guide-
to-accountable-care-organizations-and-their-role-in-the-
senates-health-reform-bill/.

12. Fried B. Accountable care organizations: navigating the
legal landscape of shared savings and coordinated care.

13. Centers for Medicare and Medicaid Services. Medicare
“accountable care organizations” shared savings program —
new Section 1899 of Title XVIII — preliminary questions
and answers. Available at https://www.cms.gov/Officeof-
Legislation/Downloads/AccountableCareOrganization.pdf.

14. American Hospital Association. AHA analysis — account-
able care organizations AHA research synthesis report. June
2010. Available at http://www.aha.org/aha/content/2010

15. Ortolon K. Just another new dress on an old pig? Account-
able care organizations tie payment to accountability,


17. Spangler L. Overview of accountable care organizations:
HMO retread or visionary path to reforming health care?
Texas Medical Association.

18. Texas Hospital Association. Accountable care organizations:
bending the cost curve toward more efficient care.

19. Texas Medical Association. Overview of accountable care
organizations: HMO retread or visionary path to reforming
health care.

20. Yaeger AN. Accountable care in Texas: A case study of
Scott & White Healthcare. Theses and Dissertations.
unt.edu/theses/85

for accountable care organizations. Available at http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/
privatehealthplans/payment/acos/20101117.Par.0001.File.
tmp/AAFP-ACO-Principles-2010.pdf.

22. American Medical Association. Protected model physician
employment agreement.

23. Bailey SR. Caution: six important points every
physician should consider about Medicare ACOs.
Texas Medical Association. September 2010. Available
at http://www.texmed.org/hsr/.
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ARE YOU CONTRACTING AWAY YOUR RIGHT TO BE INSURED BY TMLT?

If you are thinking about becoming employed by a Non-Profit Health Organization (NPHO) aka 5.01(a) or if you or your employer are thinking about joining an emerging Accountable Care Organization (ACO),

DID YOU KNOW THAT:

1. You may not be able to keep or choose your medical liability insurance carrier. Consequently, you may be required to put your reputation and assets in the hands of the organization’s self-insured entity rather than with the proven insurance professionals at TMLT.

2. You may lose the right to withhold consent to settle if a claim occurs. The insurer provided by your employer may be making the decision whether to defend or settle your case.

3. You may have to purchase tail coverage. Unless your new insurer is providing prior acts coverage, you will have to purchase tail coverage. Your new employer may not cover the cost for tail coverage. Additionally, you may lose a) the free tail coverage that you had earned with your current carrier, b) your accrued claim-free discounts, and c) the portability of your policy should you later leave.

4. You may lose your right to an independent, physician-focused defense. For instance, if you are insured by a hospital’s captive insurer, its attorneys will have expertise in defending hospitals, but may not have expertise in defending physicians. TMLT claim staff and defense attorneys specialize in defending physicians in lawsuits. Does the hospital’s insurance company have a claims philosophy that focuses on individual physicians’ risk exposures independent of the hospital’s organizational interests? Who will be protecting your career in the event of a claim or lawsuit?

IN ADDITION:

5. What if there are conflicts of interest in a lawsuit? The potential for conflict exists in certain cases when you share a defense with your employer’s appointed counsel (i.e., a joint defense). Can you be certain such conflicts will be resolved in your interest rather than that of the employer who may retain certain control over the insurance carrier? This could even lead to settlement of a defensible case.

6. What if there are disciplinary proceedings? Will the policy reimburse you for expenses to defend a Texas Medical Board investigation or peer review complaint? What if the hospital or employer has initiated the disciplinary proceeding against you? Who will represent you?

7. Will you have enough coverage? Is the aggregate limit on the employer’s policy a group aggregate? If there are several significant claims filed during the policy year, will the available limits be sufficient for your claim? What happens if they are not?

8. What about “moonlighting” coverage? If you perform activities outside of your employment, do you have to purchase coverage for these activities at your own expense? Will you be assuming the liability of your employer under a hold-harmless and indemnification clause for these outside activities?

9. What happens if there is a voluntary or involuntary termination? If the contract contains a non-compete covenant, you may have to leave the area and practice elsewhere. Or, you may have to exercise the buy-out option (which could be a year’s salary) in order to practice in the same area. Will tail coverage or prior acts be available and affordable at the time of separation? Will you be able to obtain a copy of your individual loss history for the period of your employment?

10. Beware of any promises not made in writing. The employer can change the employment contract when due for renewal. What they may offer now or agree to accommodate today could be taken away tomorrow — and if you don’t like the changes or you have decided you no longer wish to be under an employment agreement, you may find it difficult to exit and still be able to practice medicine in your desired location.

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Surgical complications

By Louise Walling and Katie Stotts

Presentation

A 65-year-old woman came to a general surgeon who specialized in gastrointestinal procedures. The patient’s chief complaint was diarrhea alternating with constipation for several months. The patient was morbidly obese and had a history of hypertension and chronic renal disease.

Physician action

After two colonoscopies, a barium enema, and a CT scan, the patient was diagnosed with sigmoid diverticular stricture secondary to chronic diverticulitis. The CT scan report noted a possible carcinoma in the area.

The patient was admitted to the hospital for a sigmoid resection to be performed by the general surgeon. During the surgery, it was discovered that the colon was attached to the pelvic wall. The general surgeon also discovered a large uterine fibroid. He called in a gynecologist, who performed a supracervical hysterectomy.

Following surgery, the patient became oliguric and subsequently anuric. A nephrologist was consulted, and his work up revealed a possible problem with the left ureter. A urologist performed a retrograde cystogram that showed extravasation from the left ureter. The pathology report from the resection indicated that the specimen of colon contained a segment of the patient’s ureter.

The patient was taken back to surgery. The general surgeon, assisted by the urologist, performed a laparotomy. The dissected ureter was identified and a nephrostomy tube was placed. However, the ureter still had a large gap that could not be re-anastomised. It was unclear whether there had been a hole in the original anastomosis, or if a pre-existing hole was not been seen by the general surgeon during the resection.

Following surgery, the patient’s renal function deteriorated. She was placed on a ventilator, and later developed sepsis and hypotension. She died six days after the resection.

Allegations

A lawsuit was filed against the general surgeon. The allegations included:

- failure to optimize the patient’s fluids and electrolytes before surgery;
- failure to take the patient’s renal failure into consideration by consulting a nephrologist before the surgery;
- failure to obtain documented consent from the patient’s husband before performing a hysterectomy;
- failure to identify the ureters and perform careful dissection in a difficult surgical area;
- failure to ensure a leak-proof anastomosis by stapling instead of hand sewing;
- failure to perform radiological investigations for possible urological injury; and
- failure to document the status of the abdominal wound during the postoperative period, and to treat related complications.

A lawsuit was also filed against the gynecologist.

Legal implications

Defense consultants were not supportive of the general surgeon’s overall care. The general surgeon did not document that he identified the ureter or preserved it. Since the patient had chronic renal disease, the injury to the ureter likely contributed to the patient’s acute renal failure.

Risk management considerations

Communication with the patient or the patient’s family is vital in medicine. Although the patient was a 65-year-old postmenopausal woman, was it possible for the surgeon to slip out of the OR and inform the patient’s spouse of the findings and the need for the hysterectomy? If — in the medical judgment of the surgeon — the patient’s status was stable enough, it may have been best to inform the spouse about the unexpected hysterectomy.

A detailed operative report is critical when surgical complications ensue. The defendant failed to document that the ureters were identified and preserved during the procedure. Each of the defense experts who reviewed this case felt that identifying and charting that the ureters were preserved was the standard of care.

Disposition

This case was settled on behalf of the general surgeon. The case against the gynecologist was dropped.
Failure to diagnose cervical cancer

By Louise Walling and William Malamon

Presentation

On July 7, a 62-year-old woman came to her ob-gyn for a well-woman exam and treatment of a vaginal wart. The patient’s medical history included normal PAP screenings and a two-year history of vaginal warts.

Physician action

The ob-gyn diagnosed a cervical polyp and performed a PAP screen. The results from the PAP screen were received by the ob-gyn on July 20. The diagnosis was epithelial cell abnormality and atypical squamous cells of undetermined significance. The pathology report was stamped with confirmation that the patient was notified of these results by letter on August 9. The letter, sent by the ob-gyn, notified the patient of the positive HPV result and stated that the results would be discussed fully at the next office visit.

Before the ob-gyn received the PAP screen results, the patient returned to the ob-gyn’s office with complaints of constant right lower quadrant pain. The pain was associated with loose stools. A polypectomy was performed and the diagnosis was endocervical polyps with focal squamous metaplasia and no evidence of dysplasia or malignancy. The pathologists commented that the atypical cells were “suspicious for HPV effect and the cells are not present in the current biopsy specimen. The disagreement may reflect sampling errors or regression of lesion. Clinical correlation is suggested with follow-up studies as clinically indicated.” The ob-gyn believed that the patient’s pain was gastrointestinal, but he ordered a pelvic ultrasound to investigate.

At an office visit on August 26, the ob-gyn noted that the patient’s right lower quadrant pain had resolved after a colonoscopy. The results from the pelvic ultrasound revealed an “ill-defined area of increased echogenicity” in the fundus of the uterus. A CT scan was recommended. The results of the previously abnormal PAP screen were attributed to the cervical polyp. The ob-gyn scheduled the patient for a follow-up PAP screen in November. His plan was to perform a colposcopy if the follow-up PAP screen was abnormal.

A CT scan and MRI performed after this visit suggested the possibility of adenomyosis or endometrial carcinoma. On September 3, the ob-gyn reviewed the MRI report and believed that adenomyosis was more likely than carcinoma. At this visit, the patient complained of back pain and was referred to an orthopedic specialist.

The patient continued to complain of low back pain and lower abdominal pain. At an office visit on January 20, the pelvic exam was reported as normal. A repeat PAP screen was negative for intraepithelial lesion and malignancy. The HPV test was read as negative. The ob-gyn recommended a pelvic ultrasound, but the patient refused.

On March 14, the ob-gyn’s office manager contacted the patient and asked her to return for an endometrial biopsy. Several additional calls were made. On April 12, the patient advised the ob-gyn’s staff that she was thinking about the hysteroscopy and biopsy and would let the ob-gyn know about her decision.

Five months after this last conversation, a CT scan performed at a local hospital revealed a retroperitoneal lymphadenopathy with multiple pulmonary lesions, a complex pelvic mass with findings suggestive of metastatic cancer. Medical records stated the diagnosis was stage IV adenosquamous carcinoma of the endocervix. However, a later pathology report indicated the origin of the cancer was uterine.

The patient underwent radiation and chemotherapy, but she died six months after her diagnosis. Records from the cancer treatment center indicate that the primary site for the cancer was initially thought to be endocervical cancer, but may have ultimately been intrauterine.

Allegations

A lawsuit was filed against the ob-gyn, alleging that he breached the standard of care by failing to perform a colposcopy and endometrial biopsy after the patient’s first abnormal PAP screen and positive HPV reading. The plaintiffs claimed that had the patient’s cervical cancer been detected earlier, the patient could have been successfully treated.

Legal implications

The plaintiffs stated that the ob-gyn should have performed a colposcopy and endometrial biopsy after the patient’s first abnormal PAP screen and positive HPV reading. The plaintiffs claimed that had the patient’s cervical cancer been detected earlier, the patient could have been successfully treated.

Defense experts who reviewed this case expressed mixed opinions about the defendant’s actions. Some experts stated the ob-gyn should have recommended a colposcopy and biopsy after the first positive PAP screen. Other experts stated that they did not believe the PAP screen results were definitive of cervical cancer. The polyp could have caused the positive results on the PAP screen. Additionally, because the screening result did not mandate a colposcopy, the ob-gyn was within the standard of care to perform a repeat cytology and PAP screen in six months.

continued on page 20
The defendant stated that he discussed the recommendations for a colposcopy and biopsy with the patient at the time of the first PAP screening, but did not document this discussion in the medical record. The first documentation of that recommendation was made several months later.

Causation was also an issue in this case. The patient was diagnosed with a very aggressive form of cancer. The defense argued that it was unlikely earlier diagnosis would have changed the patient’s outcome.

**Risk management considerations**

Documenting treatment options and rationale is part of a good medical record. This should also include that the risks of refusing a treatment were discussed with the patient. Physicians may also ask patients to sign an informed refusal treatment form. In this case, the ob-gyn recalled offering the patient an endometrial biopsy and colposcopy after the first abnormal Pap screen. However, this discussion was not documented in the record.

**Disposition**

This case was settled on behalf of the ob-gyn.