BUSINESS OF MEDICINE

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A Magazine for Physicians

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MEDSCAPE.COM/BUSINESS

HELP SHATTER **HCV** BY **LINKING** YOUR PATIENTS TO **CURE**

A PROMPT, QUALITY REFERRAL IS VITAL TO GIVE YOUR PATIENTS THE BEST CHANCE OF BEING CURED.[1]

Your role in HCV makes an impact on patients' lives.

HCV = hepatitis C virus
Cure, or sustained virologic response (SVR12), is defined as undetectable levels of HCV in the blood at 12 weeks after completion of therapy.[1,2]

References: 1. AASLD, IDSA, IAS-USA. http://www.hcvguidelines.org. Accessed September 21, 2017. **2.** HHS/FDA/CDER. Guidance for Industry. Chronic Hepatitis C Virus Infection: Developing Direct-Acting Antiviral Drugs for Treatment. November 2017. **3.** Holmberg SD et al. *N Engl J Med.* 2013;368(20):1859-1861. **4.** McGowan CE et al. *Liver Int.* 2012;32(suppl 1):151-156.

AS MANY AS **1/3 OF THOSE WHO TESTED HCV POSITIVE** DID NOT RECEIVE FOLLOW-UP CARE[3]

TREATMENT DELAYS CAN **INCREASE THE MORBIDITY AND MORTALITY RISKS** OF HCV[1]

TAKE ACTION: LINK ALL OF YOUR DIAGNOSED HEPATITIS C PATIENTS TO CARE

Inform and educate your patients that HCV often can progress without symptoms and that the earlier treatment is initiated, the more likely they can achieve cure[1]

Find and schedule the appointment with a provider who treats HCV and is conveniently located for your patients

Follow up to ensure the patient saw a treatment provider because **25% to 50%** of HCV patients miss their first appointment[4]

Consider treating HCV in your practice to help mitigate drop-off in follow-up care

REFER HCV SCREEN DIAGNOSE

Find information, tools, and educational resources on screening, diagnosing, and referral at **HCVcanbecured.com/J13** or download the **RETHINK HCV app** from the App Store or Google Play.

IS MEDICINE A PROFESSION OR A BUSINESS?

LESLIE KANE, MA
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MANY PHYSICIANS LAMENT THAT MEDICINE IS NO LONGER A NOBLE CALLING AND HAS BECOME JUST A BUSINESS. They feel rules and requirements have changed the field to the point that dedication and quality of service now come second, behind a focus on making money.

The difference between business and profession is a continuum, with many gradations between the two. The primary motive of a business is earning a profit; the basic objective of a profession is rendering a service, and profit is supposedly secondary. Professions typically have ethical standards that reinforce this emphasis.

There are several other differences between a business and a profession, but service versus profit seems to be the crux of the issue.

Where's the tipping point? Physicians are allowed to want to earn a good living; and if rules and changing insurance reimbursement make it increasingly harder, many will ramp up their efforts to bring in more money. They may add ancillary services, see more patients per day, or adopt other tactics. Some physicians find this obvious drift uncomfortable.

Many patients have noticed it, too. It's part of the reason why the public often has mixed feelings about physicians. Our insightful article, "America's Love/Hate Relationship with Doctors," written by a physician, talks about this phenomenon and makes for interesting reading.

Speaking of finances, see our helpful article about negotiating your job contract. Many physicians have told us that the actual negotiating "conversation" is nerve-racking for them. So we're bringing you expert advice on how to be successful at this process. For even more information on the subject, check out Medscape Physician Business Academy at Medscape.com.

– Leslie Kane

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MALPRACTICE REPORT

REAL PHYSICIANS. REAL LAWSUITS.

Medscape's "Malpractice Report 2017: Real Physicians. Real Lawsuits." asked physicians about various aspects of their malpractice lawsuits, from what triggered the suit and whether it was warranted to how it affected the way they practice medicine. More than 4,000 physicians across more than 25 specialties responded, and they provided some interesting results. Here are some key findings. **Check out the full report at Medscape.com/2017-malpractice-report.**

TOP 5 REASONS PHYSICIANS WERE SUED

1. Failure to diagnose or a delayed diagnosis **(31%)**
2. Complications from treatment or surgery **(27%)**
3. Poor outcome or disease progression **(24%)**
4. Failure to treat or delayed treatment **(17%)**
5. Wrongful death **(16%)**

97% of physicians have malpractice coverage

TOP 5 THINGS PHYSICIANS WOULD HAVE DONE DIFFERENTLY

1. Had better chart documentation **(22%)**
2. Never taken on the individual as my patient in the first place **(12%)**
3. Ordered tests that would have "covered" me in case a malpractice suit was brought against me **(10%)**
4. Been more careful in the way I phrased things to the patient **(8%)**
5. Spent more time with patient and his/her family **(8%)**

HAVE YOU EVER BEEN NAMED IN A MALPRACTICE LAWSUIT?

55% of physicians have been named in a lawsuit

48% were involved in suits where other parties were named

13% were involved in suits where they were the only person named

WAS THE LAWSUIT WARRANTED?

89% No

5% Yes

6% Unsure

WHICH SPECIALTIES ARE MOST OFTEN SUED?

Surgery **85%**

Ob/Gyn and Women's Health **85%**

Otolaryngology **78%**

Urology **77%**

Orthopedics **76%**

35% of physicians reported there was a trigger incident that sparked the lawsuit

PHYSICIANS' RECOMMENDATIONS FOR DISCOURAGING LAWSUITS:

- Avoid burnout
- Tort reform
- No-fault-settlement caps
- Penalize frivolous suits

RUDE PATIENTS GET WORSE CARE

Researchers recently found that rudeness had adverse effects on diagnostic and intervention activities, information and workload sharing, and helping and communication.

In the study, which appeared in *Pediatrics*, 39 neonatal intensive care unit teams participated in a training workshop including simulations of acute care of term and preterm newborns. In each workshop, two teams were randomly assigned to either an exposure to rudeness, in which a patient's mother made rude statements unrelated to the teams' performance, or control (neutral) comments. Two additional teams were assigned to rudeness with either a preventive or therapeutic (narrative) intervention.

Researchers concluded rudeness has negative effects on medical teams' performance and the collaborative attitudes essential for patient care and safety.

"People may think doctors should just 'get over' the insult and continue doing their job," said Amir Erez, University of Florida management professor and coauthor of the study. "However, the study shows even if doctors have the best intentions in mind, as they usually do, they cannot get over rudeness because it interferes with their cognitive functioning without an ability to control it."

MORE PHYSICIANS HEAD FOR LOCUM TENENS WORK

A growing number of hospitals and other healthcare facilities are attracting temporary, or locum tenens, physicians to fill gaps in their medical staffs, according to a new survey from Staff Care, a locum physician placement firm.

Staff Care's 2017 Survey of Temporary Physician Staffing Trends found that **94% of hospitals, medical groups, and other healthcare facilities used temporary doctors in 2016**—an increase from 91% in 2014 and 74% in 2012.

The survey, which queried approximately 900 physicians who work as locum tenens, found that the majority of them work between one and three temporary assignments per year; 75% are 51 years of age or older; 43% are in a permanent position but "moonlight" at temporary jobs; and **most (89%) cite freedom and flexibility as the primary benefits of working as a locum.**

Staff Care estimates some **48,000 physicians worked locum tenens in 2016**—almost double the number in 2002.

For more on the topic, search Medscape online for the article "Considering Locum Tenens? Freedom, Good Pay, and Some Risks."

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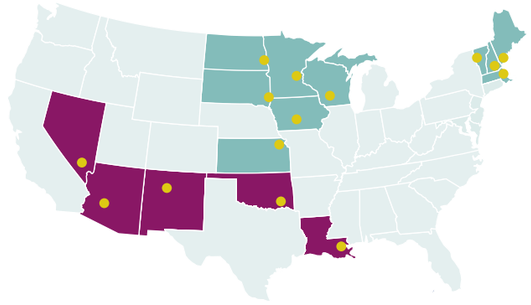
MAP KEY: Best Places Worst Places



BEST PLACES TO PRACTICE TO AVOID BURNOUT

Medscape's 2017 ranking of best and worst places to practice focuses on locations that help you avoid stress and burnout and create a calmer, happier life. The ratings were determined by evaluating 12 separate state-based rankings compiled by outside sources and cover many factors that contribute to burnout.

1. **Minneapolis, Minnesota,** topped the list of 25 best places. Physicians have a relatively healthy population, and the state is family-friendly, with many outdoor diversions.
2. **Madison, Wisconsin,** residents display a high level of happiness and are involved in fewer lawsuits, and a high percentage of physicians are employed.
3. **Sioux Falls, South Dakota.** Although there are some safety issues here, physicians have high incomes and a low number of malpractice suits. Sioux Falls also has a strong economy and low stress levels.

ROUNDING OUT THE LIST:

4. Des Moines, Iowa
5. Burlington, Vermont
6. Manchester, New Hampshire
7. Boston, Massachusetts
8. Fargo, North Dakota
9. Portland, Maine
10. Overland Park, Kansas

Which are the five worst places to practice? New Orleans, Louisiana; Phoenix, Arizona; Las Vegas, Nevada; Albuquerque, New Mexico; and Tulsa, Oklahoma. Factors involved in these included high rates of malpractice suits, crime, and homelessness; excessive heat; and high unhappiness ratings.

To read more about the 25 best places to practice and the five worst places, see our report at Medscape.com/business.

PHYSICIANS WEIGH IN ON

THE TOP HOSPITALS IN THE U.S.

Physicians, more than the general public, know what makes a hospital (or a department within a hospital) a recommended place to get medical treatment. Medscape's report, "Physicians' Choice: Top Hospitals 2017," provides doctors' valuable assessment of the 10 best hospitals for nine different clinical conditions or procedures: breast cancer, prostate cancer, hip replacement, cardiac conditions, interventional cardiac surgery, infectious disease, stroke, multiple sclerosis, and lung cancer.

Physicians were asked, "Suppose you or someone in your family were just diagnosed with a complex or difficult case of [condition]. Assuming that there are no barriers (e.g., transportation costs) to treatment at the hospital you prefer, what hospital would you choose for treatment?"

More than 8,500 physicians responded. The following results are based on responses from physicians in all specialties.

PHYSICIANS' CHOICE: TOP HOSPITALS FOR BREAST CANCER

1. Memorial Sloan Kettering Cancer Center
2. MD Anderson Cancer Center
3. Mayo Clinic Hospital – Rochester
4. Dana-Farber Cancer Institute
5. Cleveland Clinic
6. Johns Hopkins Hospital
7. Stanford Health Care
7. City of Hope's Helford Clinical Research Hospital
7. Duke University Hospital
10. UCSF Medical Center
10. Brigham & Women's Hospital

PHYSICIANS' CHOICE: TOP HOSPITALS FOR HIP REPLACEMENT

1. Hospital for Special Surgery
2. Mayo Clinic Hospital – Rochester
3. Cleveland Clinic
4. Rush University Medical Center
4. New England Baptist Hospital
4. Johns Hopkins Hospital
4. Massachusetts General Hospital
8. Duke University Hospital
8. UCSF Medical Center
8. Cedars-Sinai Medical Center

PHYSICIANS' CHOICE: TOP HOSPITALS FOR INTERVENTIONAL CARDIAC SURGERY

1. Cleveland Clinic
2. Mayo Clinic Hospital – Rochester
3. New York-Presbyterian Hospital
4. Massachusetts General Hospital
5. Johns Hopkins Hospital
6. Stanford Health Care
7. Brigham & Women's Hospital
7. Cedars-Sinai Medical Center
9. Duke University Hospital
9. UCSF Medical Center
9. Hospital of the University of Pennsylvania

FOR THE FULL LIST, SEE **MEDSCAPE.COM/SLIDESHOW/TOP-HOSPITALS-2017-6008909**

MEDSCAPE'S MENTOR OF THE YEAR

AN INTERVIEW WITH **DONNA MAGID, MD, MEd**

BY RYAN SYREK, MA

JULIA ROBINSON

Donna Magid, MD, MEd, was awarded the first-ever Medscape Mentor of the Year award as part of the WebMD Health Heroes awards in late 2017 for her work at Johns Hopkins University School of Medicine. In addition to her role in developing and overseeing education programs and curricula, Dr Magid is an active member of the Association of University Radiologists, through which she routinely participates in a national mentoring program. She is also the creator of Team Rads, an anatomy education website hosted by Hopkins School of Medicine, and Apps of Steel, a comprehensive radiology residency advice guide.

MEDSCAPE: Can you tell me why you feel that mentor relationships are so crucial?

DR MAGID: In part, I'm imposing my own experience on my students. I was a last-minute applicant for medical school. I really wasn't on a premedical path. I was talked out of a psychology PhD because all of the interesting clients were going to get MDs instead of PhDs. I shocked myself and got in on the first try.

I was just wildly lost. It was overwhelming, and the support of the dean of students was priceless. He said, "You're not going to do well in basic science, we know that. You're going to do great in other areas." No one had ever said that to me before.

Dr Levi Watkins was extremely important to me, as was Dr Stan Siegelman, a radiologist. They made me feel very secure about things. I've never forgotten it. I feel I owe it to them to do the same thing for other people.

MEDSCAPE: What do you think older, experienced doctors get from mentoring younger students or doctors?

DR MAGID: I feel that I'm partly a catalyst. I'm not giving them potential; I'm simply applying the ability to recognize the potential. When I enable them to grow, it's more gratifying than if I grow myself. Everything has an expiration date; research becomes dated. If you keep energizing juniors, they do better and get the confidence themselves to try something. It's like self-perpetuating perpetual motion, outlasting any one individual.

Our workloads are expanding, the financing is tighter, people aren't always getting reimbursed at an adequate level, and it's exhausting. But the one thing in my day that doesn't exhaust me is teaching or talking to either my residents or my med students. It is worth it.

Sooner or later, we all move on; we retire, we step down, we get our time, we go into something else. But if I left all of these people behind me enabled, energized, and encouraged, then I did some good that lasts a little bit longer than just reading some cases or helping a clinician.

AMERICA'S LOVE/HATE RELATIONSHIP WITH DOCTORS

ONE PHYSICIAN EXPLORES THE QUESTION OF WHY SOME PATIENTS BOTH ADMIRE AND RESENT PHYSICIANS

BY PAMELA L. WIBLE, MD

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AMERICA HAS MIXED FEELINGS ABOUT PHYSICIANS.

On the one hand, doctors often top lists of "most admired" and "most respected" professions in the United States. Some people seem to admire physicians' education and brainpower and feel that—particularly among some specialties—some doctors have the ability to save their lives and/or improve the quality of their lives.

But among many other people, there's an identifiable backlash against and resentment of physicians. Some of this revolves around doctors' incomes and ability to afford certain luxuries. Other elements seem to be related to the fact that their own physician doesn't spend as much time with them as they would like or makes decisions, such as ordering testing and additional visits, that they consider driven more by money than care. And there are those patients who say that their doctor doesn't appear to be as selfless and devoted to them as they believe that physicians in general should be.

The truth of the matter is that a large degree of America's love/hate relationship with doctors is fueled primarily by our idealized notion of what a doctor should be. When asked to describe their vision of an ideal doctor, patients often use such words as *empathetic, wise, confident, attentive, brilliant, dedicated, and altruistic.* But they want *trust, friendliness, respect, honesty, timeliness,* and *sincerity,* too.

That's an awfully high pedestal. And these expectations extend to physicians' lives and behavior outside the office as well.

How did we get here? Once upon a time, long ago—before third parties inserted themselves into medicine—we had the doctor and the patient. Alone. In one room. The relationship between doctor and patient was undisturbed by layers of bureaucracy, faxes, and phone trees, uncorrupted by superbills and CPT codes.

When we fail to meet our patients' expectations, however, all hell breaks loose. And rather quickly.

"Although most of my patients are delightful, I have a subset who love me if what they want and what they need are the same, and they hate me if I tell them what they don't want to hear," says Christin Hominski, MD, an internist in Norwich, Connecticut.

John Joseph Shigo, MD, a family medicine practitioner in Kensington, Maryland, agrees: "Our patients love us when we make the right medical decisions but hate us if any complications occur."

This is another factor that creates more mixed emotions among patients: They don't feel that it's enough for doctors to "do their best." Rather, patients have an overblown idea of the actual extent of medical knowledge, the availability and sensitivity of all tests, and the infallibility of decision trees.

"Our patients love us when we make the right medical decisions but hate us if any complications occur."

Still, patients tend to love their own doctor and distrust others. At a malpractice risk-reduction workshop, my colleagues and I heard about a woman who sought legal counsel for a bad outcome. The attorney pulled out a list of all the physicians involved in her case for her review before deciding which ones to name in the lawsuit. The patient replied, "Sue them all, except this one—he's my doctor."

It is the relationship that helps determine patients' overall view toward the physician. Without the relationship, patients judge us harshly. Especially when it comes to money.

JUDGE ME NOT BY MY BANK ACCOUNT

"If a doctor drives a good car, they're assumed to be making too much money. If they drive a humble car, they're considered cheap," says pediatric gastroenterologist Rima Jibaly, MD, who practices in Flint, Michigan. It's this "can't win either way" feeling that makes it difficult for physicians to discuss certain things they have in common with their patients—be it houses, vacations, schools, or cars.

And yet, are physicians required to be more selfless than other high-earning professionals, such as lawyers and financial planners? Aren't we entitled to be materialistic at times, if we do a good job of caring for people?

Some patients say physicians are indeed very deserving. "I don't care how much money my doctor makes, because I know they give up so much of their youth, time, and money to become doctors and help people," said one patient. "But I do care if they listen to me. So when I find a good doctor who listens to me, I become very fond of them."

The truth is that without the relationship, health care becomes a mere financial transaction between a customer and a service provider. And many physicians these days feel that the doctor/patient relationship is really no more than that in most cases.

"As a physician, I feel that the only respect people have for me now is that I spent a lot of time and money to get an MD behind my name," says one physician from Colorado. "They don't really respect my opinions about their health, because they can find all the info they need on the internet."

The underlying problem is that patients don't know doctors as people anymore, says family physician Liz Hills, DO, who practices in Elk Mountain, Wyoming. "What they love is the doctor archetype/myth," Dr Hills explains. "What they hate is the broken system, and doctors are perceived to be the face of the system."

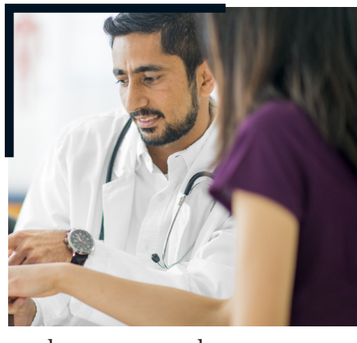
SALVAGING THE RELATIONSHIP

Restoring the fractured relationship between doctor and patient is key to ending the hatred of physicians. To do that, we need uninterrupted time with our patients.

One step to the cure is disintermediation—removing the no-value-added intermediaries who have inserted themselves between doctor and patient. Many doctors are fleeing big-box, assembly-line medicine for concierge or "ideal" clinics. Ideal doctors are giving up production-driven medicine for relationship-driven models. This is a positive step in the right direction.

There are a lot of conflicts in medicine—between doctors and patients, between doctors and administrators, and between doctors and each other. But ultimately, even though physicians earn a very good living in comparison with the typical American, most doctors put the practice of medicine first, far above prestige and money. If we flaunt anything, it's usually our incredibly specialized knowledge, which redounds to the benefit of patients themselves.

Patients don't care what you know, unless they know that you care. And if you care, they will care less how much money you make.



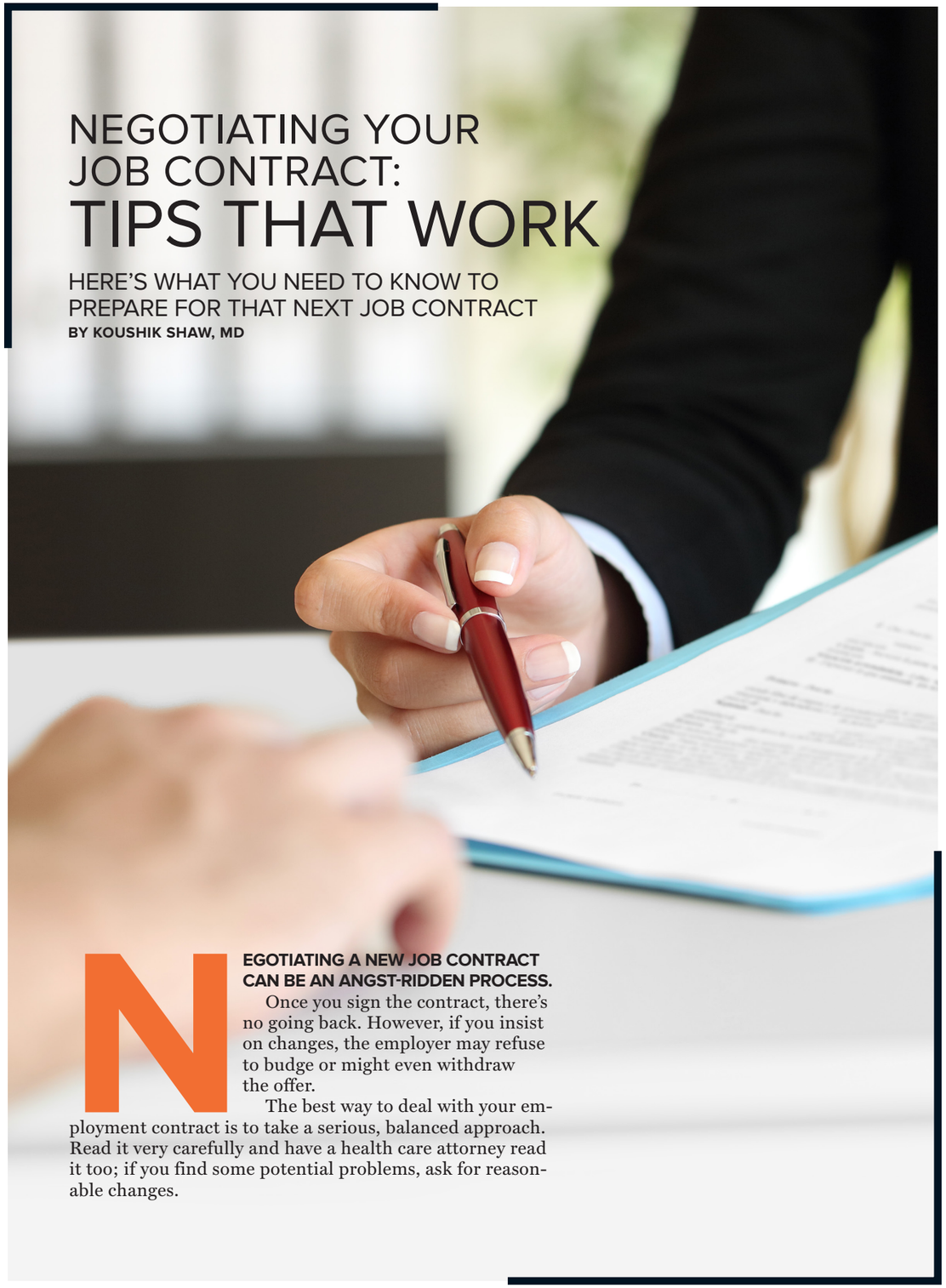
Most patients, I've found, truly want doctors they love, trust, respect, and admire.

Pamela L. Wible, MD, is author of Physician Suicide Letters—Answered.

NEGOTIATING YOUR JOB CONTRACT: TIPS THAT WORK

HERE'S WHAT YOU NEED TO KNOW TO PREPARE FOR THAT NEXT JOB CONTRACT

BY KOUSHIK SHAW, MD



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NEGOTIATING A NEW JOB CONTRACT CAN BE AN ANGST-RIDDEN PROCESS. Once you sign the contract, there's no going back. However, if you insist on changes, the employer may refuse to budge or might even withdraw the offer.

The best way to deal with your employment contract is to take a serious, balanced approach. Read it very carefully and have a health care attorney read it too; if you find some potential problems, ask for reasonable changes.

Most employers are not going to fight a limited number of changes that would make you happy. After all, they spent a great deal of time and money trying to recruit you, and they really don't want to start the process all over again. The main reason that contracts are signed without any changes at all is that many new physicians don't want go through all the anxiety.

Here are a few tips for successfully negotiating a contract.

HOW TO PREPARE FOR SUCCESSFUL NEGOTIATIONS

Review the contract. When the contract is sent to you, you should immediately send a copy to your lawyer and be sure to read it carefully yourself. After all, these are the rules you would be working under as long as you're in the job (though some tweaking may be possible in future contracts).

If someone else held the exact same job before you, you could ask the employer for this doctor's wRVU level.

Read the contract sentence by sentence at least three or four times. Detailed knowledge will make you a better negotiator. But even then, you'll still have to play an integral role.

Make a list of provisions that bother you, and prioritize them. Start with concerns that would be deal-breakers, followed by concerns that you might be willing to compromise on. Share this list with your attorney, who may come up with very different items, including contract pitfalls.

Sort the provisions. Some contract provisions are generally easier to negotiate. These include the start date, some aspects of the work schedule, and fringe benefits such as a signing bonus and funding for continuing medical education (CME). Base salary, productivity bonuses, and issues around termination are often harder to change.

EFFECTIVE WAYS TO NEGOTIATE THE CONTRACT

Plan ahead. Once you have a meeting with your prospective employer, work from a script. If you negotiate by phone or in person, it's helpful to draft a few talking points on critical issues. Have your attorney review your script.

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Be prepared for compromises. This isn't like buying a car, where you might never see the dealer again. These are people you can expect to be working with for many years to come. Continue to build strong relationships with them.

Don't accept reassuring verbal statements. You'd be right to doubt such assurances as "Our attorney always puts that in there" or "That won't apply to you." If a term is in the contract, it does indeed apply to you. Conversely, if a statement isn't in the contract, it doesn't exist.

UNDERSTANDING AND NEGOTIATING FOR COMPENSATION

Some practices still base compensation on the physician's share of collections, which is a pretty easy concept to understand. Increasingly, however, payment is based on productivity—even in practices.

Productivity is measured in work relative value units (wRVUs), which have a specific value for each billing code. Because this approach ignores reimbursement levels, physicians with a lot of Medicaid or capitated patients can be paid quite well under wRVUs.

If someone else held the exact same job before you, you could ask the employer for this doctor's wRVU level. This figure would be more accurate than anything you could calculate on your own.

PARTNERSHIP TRACK IN A PRIVATE PRACTICE

When hired by a practice, you start as an employee but usually can expect to become a partner in a number of years. Some practices can deliberately make it hard to reach partner level.

Try to add specific criteria to the contract, such as setting a timetable for the transition and a list of costs included in buyouts.

Making partner usually means buying into the practice. The amount you have to pay should be based on an outside financial analysis. And rather than paying the sum all at once, you should be able to make payments over time.

OTHER ASPECTS OF THE CONTRACT TO WATCH OUT FOR

Some other possible provisions to watch out for in a contract include automatic renewal without your consent and allowing the contract to expire in the event of a buyout of the practice; tail coverage; non-compete clause (restrictive covenant); and termination clause.

Koushuk Shaw, MD, is a urologist at the Austin Urology Institute and author of The Ultimate Guide to Finding the Right Job After Residency.

SHOW ME THE MONEY

Try these effective tactics for negotiating compensation

- **Keep an eye on base salary.** This is important, because qualifying for the bonus will require you to reach a target figure that may be unattainable. Furthermore, the base amount may be hard to change in ensuing contracts.
- **Don't be swayed by your first-year salary.** You'll probably be paid a guaranteed salary in the first one to three years, and it can be quite generous. But after you shift to a compensation formula, your income might actually fall. For those reasons, you should focus on the formula.
- **One-time payments don't reflect the long term.** The employer may offer you a hefty signing bonus, cover your moving expenses, and even pay off part of your student loans. But these are one-time payments, and you might have to pay them back if you leave before the contract expires.
- **Keep your eye on productivity targets.** The compensation formula is typically made up of a base salary plus a productivity bonus, which isn't paid unless you meet the wRVU target. The target can be set too high.
- **Income-based compensation can be knotty.** Many groups still base compensation on practice income minus expenses. Find out whether your income would be based on your own collections, or whether collections have to be divided evenly, even if you see more patients. And what constitutes expenses? Do they include new ventures of certain physicians in the practice?

Pay attention to what the contract says about call coverage, office hours, time off, and CME requirements. Open-ended job descriptions, such as "full-time work," fail to define the number of hours you have to work, the number of patients you have to see, and how much work you'll have on weekends and holidays.

TO SEE MORE ABOUT FINDING A JOB AND NEGOTIATING THE CONTRACT, SEE MEDSCAPE'S PHYSICIAN BUSINESS ACADEMY. **MEDSCAPE.COM/ACADEMY/BUSINESS**

ALISON SEIFFER

CAN A PHYSICIAN DELEGATE THE INFORMED CONSENT PROCESS?

Informed consent has been an essential requirement in medicine for more than a century. Except in emergencies, physicians must discuss with patients the benefits, risks, and alternatives to any proposed surgical procedure before they can operate.

Treatments and procedures are often big decisions, so doctors must engage in a give-and-take with patients, answering questions and securing written consent before going ahead with the operation or procedure. A number of physicians have begun to delegate all or part of the informed consent process to a nonphysician clinician, such as a nurse practitioner (NP) or physician assistant (PA). Is this an acceptable practice?

With the increase in team care and NPs and PAs assuming more responsibility, it's a question that will come up frequently.

COURT RULING

That was the key question in a controversial case recently decided by the Pennsylvania Supreme Court. In a 4–3 ruling, the court held that informed consent requires "direct communication between physician and patient, and contemplates a back-and-forth exchange. . . . The duty to obtain informed consent belongs solely to the physician and cannot be delegated." The court held that a physician cannot rely upon a subordinate to disclose vital information and obtain informed consent.

The American Medical Association (AMA) and Pennsylvania Medical Society disagreed. They argued that doctors can use their staff to assist in the process. The dissenting justices said that the court's decision "will have a far-reaching, negative impact on the manner in which physicians serve their patients. For fear of legal liability, physicians must now be involved with every aspect of informing their patients' consent.

"Some have claimed that this can delay seriously ill patients' access to physicians and the critical services that they provide. Courts should not impose such unnecessary burdens upon an already strained and overwhelmed occupation when the law does not clearly warrant this judicial interference." The AMA brief said that the law "focuses on what a patient has been told . . . and not on who provided it."

"Other states may have different rules, but the custom around the nation has been for the surgeon to do it himself."

THE CASE

Megan L. Shinal had undergone surgery for partial removal of a brain tumor. Several years later, the craniopharyngioma tumor had returned, along with severe headaches. She was referred to Steven A. Toms, MD, chief of neurosurgery at Geisinger Medical Center in Danville, Pennsylvania.

The tumor had grown in size to where it was jeopardizing the patient's eyesight and carotid artery and "would eventually become life-threatening" if left untreated, according to the court decision.

Dr Toms met with the patient and discussed surgery options—total versus partial removal of the tumor. The surgeon testified that he told her that less aggressive surgery could be safer, but there was a likelihood that the tumor would grow back again. The decision of how far to proceed was discussed at length, and the final determination would be made during surgery. "If you can get it all, I want you to get it all," he testified that the patient told him.

A few days later, the patient telephoned Dr Toms' physician assistant and asked questions about scarring, whether radiation would be necessary, and the date of the procedure. The PA provided her with more information about the surgery. He gave her an informed consent form that she signed.

During the operation, the neurosurgeon perforated Shinal's carotid artery, resulting in hemorrhage, stroke, brain injury, and partial blindness. At the trial two years later, the patient testified that had she known more about the alternative approach, she would have chosen partial removal of the tumor as the safer, less aggressive option.

She filed a lawsuit alleging that Dr Toms had not obtained her informed consent.

A jury found for Dr Toms. The patient appealed and challenged the trial court's informed consent jury instructions. Her attorney argued that whatever the PA told the patient during the informed consent process shouldn't be admitted into evidence because the surgeon is required to personally provide all of the information. An appeals court denied her claim, and she filed an appeal with the state Supreme Court, which reversed that decision last June. The court ordered a new trial.

IMPACT OF THE RULING

Several attorneys and physicians disagree what effect the ruling will have. Some argued that it has long been common practice for physicians to allow allied health professionals to participate in the informed consent process.

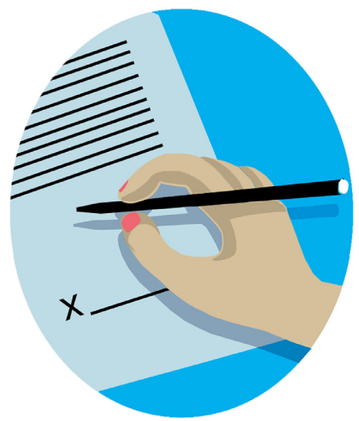
"Up until now, especially with uncomplicated straight-forward procedures, it was common that some responsibility for informed consent could be delegated," says Charles Cutler, MD, an internist and immediate past president of the Pennsylvania Medical Society. "Procedures such as colonoscopies, blood transfusions, and many biopsies are low risk and shouldn't require the surgeon to do it all."

Richard F. Cahill, JD, vice president and associate general counsel for The Doctors Company of Napa, California, the nation's largest malpractice insurer, says that the Pennsylvania Supreme Court was correct: "It's been established law for more than 100 years that the physician must personally conduct the informed consent discussion. Other states may have different rules, but the custom around the nation has been for the surgeon to do it himself."

INFORMED REFUSAL IS A PATIENT'S RIGHT

What should physicians do if the patient refuses treatment? "Informed refusal is part of the informed consent process," Cahill says. "The risks of refusing treatment must be thoroughly discussed and documented. If possible, it's best to ask the patient to sign a form. If he won't sign, ask a nurse or other staff member to note in the record that the patient was informed of the risks and decided to forego the procedure."

Physicians don't need to discuss or list every single risk that could occur. They are required to talk about likely and significant potential complications. What would a reasonable patient in a similar situation consider significant to make a decision about whether to have the procedure? "That can vary," says Cahill. "It often depends on the standard of care in a given community."



SHOULD DOCTORS EMBRACE OR REJECT ALTERNATIVE TREATMENTS?

MEDSCAPE READERS WEIGH IN

BY SANDRA LEVY

Physicians are increasingly dealing with patients who want treatments that are considered "alternative." These treatments are often untested or unapproved, but patients believe that they may work better for them than traditional medicines.

In a recent Medscape.com Both Sides Now discussion, Arthur Caplan, PhD, director of the Division of Medical Ethics at New York University School of Medicine, asked: Should doctors embrace or reject alternative treatments?

The discussion featured Dr Steven Novella, assistant professor of neurology at Yale School of Medicine, who expressed the view that complementary and alternative medicine is mostly a scam and should not be pursued. Also on hand was Dr Ronald Hoffman, medical director of the Hoffman Center in New York and a complementary medical practitioner, who holds that a natural medical approach can be the key to wellness. The discussion sparked many comments from physicians.

"I WOULD KEEP AN OPEN MIND. THIS MAKES THE PATIENT FEEL MORE COMFORTABLE, AND MORE LIKELY TO SHARE WHAT HE/SHE IS DOING AT HOME WITH SUPPLEMENTS, HERBS, ETC. HAVING SAID THAT, WE ARE INUNDATED WITH CHARLATANS EMAILING EVERYBODY AROUND WITH HOW GREAT THIS AND THAT APPROACH WOULD BE TO HEAL AND CURE JUST ABOUT EVERYTHING UNDER THE SUN, PROMOTING BOOKS, SUBSCRIPTIONS, ETC. THESE ARE MORE LIKELY TO INFLICT HARM ON UNSUSPECTING READERS THAN REALLY HELP ANYBODY."

– A RHEUMATOLOGIST

"Much of what is treated by standard medical treatments and by alternative practitioners tends to resolve on its own. This is confusing for individual patients who experience disease and treatment individually. A patient had X disease, and it was treated with Y treatment; ergo, it is assumed that X resolved Y for that individual patient. **So, individual patients can be forgiven for a lack of scientific perspective of the validity and reliability of their 'cure.' Professional practitioners cannot, in good conscience.** 'Alternative' and 'complementary' medicine is a mix of a lot of charlatanism and a bit of pre-mainstream medicine (which will ultimately be proved out). Legitimate practitioners have to be skeptical if they want to maintain legitimacy, but they should be open to evidence."

– AN EXPERT IN HEALTH BUSINESS ADMINISTRATION

GETTY IMAGES

"It is very sad that the mantra of 'there is no evidence for complementary medicine' is being repeated by so many doctors who never bother to look for the evidence. About 6,000 papers are published every year in relation to plant medicine (herbal medicine, botanical medicine)—there have been numerous RCTs that show the benefits of medicinal plants. Just type '*Curcuma longa*' or '*Hypericum perforatum*' in PubMed."

– A CLINICIAN

"THE PATIENT HAS THE RIGHT TO CHOOSE THE TYPE AND MODALITY OF HEALTH AND MEDICAL CARE, AND PLEASE REMEMBER THAT ALTERNATIVE AND COMPLEMENTARY MEDICINE IS NOT FOR EVERYONE. **PEOPLE NEED TO TAKE CHARGE AND TAKE RESPONSIBILITY FOR THEIR HEALTH AND WELL-BEING.** AN INTEGRATIVE APPROACH IS NEEDED IN THIS REGARD. I MAKE A POINT OF ENCOURAGING PEOPLE THAT I COME IN CONTACT WITH TO MAKE USE OF THE APPROPRIATE MEDICAL PROFESSIONALS."

– A PHYSICIAN

Most times, alternative treatment is level E—expert opinion. Double-blind trials are lacking, usually. Definitely placebo effects can be wonderful, at times. The atmosphere in alternative treatment centers is great and instills positivity at times, so much so that spontaneous remissions are seen and are given credit. When allopathy tells no cure, these therapies are used with hope. The hope itself improves outcomes. Lifestyle modification occurs through some of these treatments, and thus would be useful to a particular patient.

– A CLINICIAN

"I BELIEVE I AM ALIVE TODAY BECAUSE I SOUGHT OUT ALTERNATIVE PRACTITIONERS WHEN, AFTER CONSULTATIONS AND MYRIAD TESTS BY SEVEN DIFFERENT SPECIALISTS, NONE FOUND OR DIAGNOSED THE 14-CM OVARIAN CANCER TUMOR THAT HAD ME AT DEATH'S DOOR. I HAD SURGERY TO REMOVE THE TUMOR, THEN DECLINED THE HIGHLY RECOMMENDED CHEMOTHERAPY REGIMEN. I FOLLOWED INSTEAD A DETOXIFICATION REGIMEN, PH BALANCING, A STRICT ORGANIC DIET, AND SUPPLEMENTS THAT HAVE COST APPROXIMATELY $5,000–$10,000 PER YEAR. I'M CANCER-FREE, AND IT'S BEEN ALMOST 4 YEARS SINCE MY DIAGNOSIS AND SURGERY.

DOCTORS SHOULD FIRST LEARN THE FUNDAMENTALS OF ANALYZING PUBLISHED DATA OF ANY NATURE OR TREATMENT. THE NUMBER OF FLAWED PUBLICATIONS WITH REGARD TO ALLOPATHIC TREATMENTS THAT HAVE SUBSEQUENTLY BEEN SHOWN TO BE WISHFUL THINKING IS NOT INSIGNIFICANT."

– A PHYSICIAN

TO SEE THE ORIGINAL DISCUSSION, **GO TO MEDSCAPE.COM/VIEWARTICLE/886987**

DR TOPOL AND MICHAEL LEWIS ON COGNITIVE BIAS

MICHAEL LEWIS, author of *Flash Boys, The Big Short, Moneyball*, and *The Blind Side*, speaks with **ERIC TOPOL** about his new book and cognitive bias—and how it leads physicians to misdiagnoses.

ERIC TOPOL, MD

MICHAEL LEWIS

DR TOPOL: Michael, one of the things that you have [focused] on for many years—in fact, dating back to *Moneyball*—is the idea of perception and cognitive biases. What got you started with that?

MICHAEL LEWIS: In 2001 and 2002, when I was working on *Moneyball*, the Oakland Athletics organization was spending $30 million or so on its players, yet it ran circles around teams spending four times as much. And the question was, how could that happen if the market for baseball players is efficient? Part of the answer was that baseball scouts made a lot of mistakes. Plus, there were systematic misjudgments that the Oakland A's exploited, and they found better ways to value the players, namely by using statistics as opposed to using the judgement of experts. Why were the experts making mistakes? The people who started to dig into that question were a pair of Israeli psychologists, Danny Kahneman and Amos Tversky [the subjects of Lewis's latest book, *The Undoing Project*].

"They were shocked to find that the model was better at predicting whether the tumor was malignant than the individual doctors were."

DR TOPOL: Danny was available to you, but Amos [had passed away]. How did you pull it all together?

MR LEWIS: In the beginning, I started with their papers and spent an awful lot of time with Danny. Amos had left behind file cabinets filled with his papers that remained 20 years after his death. These two guys created a field of inquiry called "Judgement and Decision-Making" that spawned behavioral economics and fueled evidence-based medicine.

DR TOPOL: These are the two people who brought together the field and so many respects of behavioral science, behavioral economics, and a good understanding of human intuition going off track.

In Danny's book, *Thinking, Fast and Slow*, he got into System 1 reflexive fast thinking and System 2 reflective slower analytical thinking. It has been documented that medical diagnosis today is all System 1 thinking, and that seems to be part of the problem. You really zoomed into that [in The Undoing Project] with Don Redelmeier at Sunnybrook Hospital.

MR LEWIS: Redelmeier is a general internist at Sunnybrook in Toronto. He wanders around the hospital questioning how people got to their diagnosis. That hospital is situated next to a mammoth freeway where there are daily accidents. Ambulances rush in people in critical condition who often cannot communicate and must be diagnosed very quickly. He is in a fertile place to be questioning human judgement, and it's a wonder that this role has not spread to other hospitals and is not formalized.

DR TOPOL: He wrote a paper with Amos that you wrote about in the book.

MR LEWIS: [In this] riveting study, they used Stanford University doctors as lab rats. And Redelmeier showed what Danny and Amos had illustrated in their work—that when people make judgements or decisions about things, often they aren't deciding between the things themselves; they're deciding between the way they're described. They went to these doctors and said, "You have a patient with terminal cancer who is going to be dead within seven years. But experimental surgery can be performed on this patient and if it works, the patient's cured."

Half of the doctors were told that there was a 90% chance that the patient would survive the surgery, and the other half were told that there was a 10% chance that the patient was going to die on the operating table. It's the same thing, just framed differently. Ninety-percent survival versus 10% death. Doctors who were presented with the 90% survival statistic were more than twice as likely to want to perform the surgery.

DR TOPOL: Another study in the book regarded the influence of the patient that you are directly caring for versus knowing the literature about patients like that—and how much of the bias and judgement is influenced by that person.

MR LEWIS: Both Amos and Danny would say that it would be very useful for all doctors to have a basic understanding of regression to the mean, base rates, and statistical concepts that will actually help them think about how they diagnose, combined with a sense of cognitive biases that we know about. If we see three cases of appendicitis in a row walk into the emergency room, the fourth person who comes in manifesting some of those symptoms, but actually has something else, is more likely to be misdiagnosed with appendicitis.

The nature of the relationship between the doctor and the patient—the patient kind of regards the doctor as God, and if he got something wrong, then they assume he got it wrong for a good reason.

DR TOPOL: The contributions you've made really are impactful. Thank you so much.

TABITHA SOREN

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anti-VEGF = anti–vascular endothelial growth factor; AMD = Age-related Macular Degeneration; DME = Diabetic Macular Edema.

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