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A Letter from the Chair of the Board

Informed Patient or Bully? A Doctor's Dilemma

Dear Colleague:

Today's Internet-savvy patient has access to an unprecedented amount of medical information. There are positives to this, as more knowledgeable patients are more active in their own care, leading to better overall health outcomes. However, a Physician's medical judgment should never be compromised by patient-bullies, who believe they know the best course of action for their own care and will attempt to pressure the Physician into a treatment plan that may or may not be the best for them.

This issue of Doctors RX will demonstrate how Physicians can address patient-bullying through communication, documentation and informed decision-making principles.

*George S. Malouf, Jr., M.D.
Chair of the Board*

*MEDICAL MUTUAL Liability Insurance Society of Maryland
Professionals Advocate Insurance Company*

How would you like to be the recipient of a lawsuit or a Board of Physicians complaint involving a patient where the treatment rendered by you did not reflect your best medical judgment? How could this possibly have happened to you?

Consider the following scenario: A 59-year-old postmenopausal woman presented to her Physician with complaints of fatigue, weight gain and joint pain. Lab results indicated a TSH level of 4.0 (normal range .5 to 4.5/5.0). Her cholesterol had gone from 170 to 270 in two years (normal range 120 to 240 mg/dl), and LDL similarly went from normal to 140 (normal range 62 to 130 mg/dl). She also presented with an armful of Internet-based research about hypothyroidism and subclinical hypothyroidism, and demanded to be put on thyroid medication. Her Physician suggested trying a combination of diet and exercise first, with more frequent monitoring of blood work prior to medication. The patient became tearful and angry, stating that she'd tried everything without success and declared that she "needs medication to address her thyroid and if she didn't get it, she would sue you."

Or this: A patient arrives for an appointment requesting

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Michelle R. Mitchell, Esq.
Wharton Levin Ehrmantraut & Klein



specific pain medication and dosages for back pain because “that’s the only thing that works for me.” When you refuse in favor of more conservative treatment, the patient threatens to contact a lawyer.

These situations are not unique in today’s health care industry; in fact, one study of primary care Physicians in the United States revealed that 60.7% of Physicians reported to have been verbally bullied to write a prescription.¹ Increased Internet usage, the wealth of medical information available to the general population, as well as direct-to-consumer pharmaceutical advertising has resulted in “Dr. Google” providing diagnoses, patients acting more as consumers, and Physicians being pressured (if not bullied) into treatment plans by their patients. This issue of *Doctors Rx* places today’s Doctor-Patient relationship in historical context, expounds upon the reasons for the transformation in the Doctor-Patient relationship, (including the advent of the “patient-bully”) and provides suggestions for effectively managing these situations.



History of the Doctor-Patient Relationship

From the inception of the practice of medicine, the traditional Doctor-Patient relationship was a paternalistic one, where the Physician would decide, virtually unilaterally, what course of treatment was appropriate for the patient. Medical paternalism reasoned that patient participation in the decision-making process was unnecessary given that the Doctor and the patient both held the same goal: to protect the patient’s health.² In fact, the Corpus Hippocraticum encouraged Physicians to conceal the patient’s true condition because optimism and confidence were considered essential to the healing process.³ Society relied almost exclusively on the Physician’s obligation to act in the patients’ best interest as relieving the Physician of any duty to inform the patient of treatment options.⁴

Not surprisingly, the formation of the doctrine of informed consent caused a change in the Doctor-Patient relationship from paternalistic to more patient-driven. In the early twentieth century, case law began to recognize a “right to determine what shall be done with his own body,”⁵ which marked a shift away from the traditionally paternalistic view of the Doctor-Patient relationship. The social atmosphere in the 1950s and 1960s, in which the civil rights movement permeated the socio-political ideals, simultaneously resulted in an increased value on the rights of individual patients to determine their course of medical treatment.⁶ The term “informed consent” was first used by a California court in 1957,⁷ when it held that a Doctor must disclose all significant risks to a patient before initiating medical treatment. Maryland’s highest court adopted that doctrine in the seminal case of *Sard v. Hardy* in 1977.⁸ The doctrine of informed consent, and its applicability to Maryland Physicians today, is worthy of its own independent analysis and discussion. Suffice it to say, in the context of this article, the adoption of the doctrine of informed consent marked the transition to a patient-autonomous, or patient-driven, relationship.

While patient input was pivotal to the informed consent doctrine, the informed consent doctrine did not devalue a Physician’s judgment and experience. To the contrary, the doctrine emphasized the need for a Physician to assess the patient’s condition, utilize his or her experience and training to make recommendations as to alternative treatment options, present the risks/benefits of each, and then permit the patient to decide. Accordingly, patients heavily relied upon the Physician’s extensive knowledge and expertise; the ultimate decision making, however, became a more “shared” approach versus a unilateral or paternalistic approach.

While the shift in the Doctor-Patient relationship began in the mid-twentieth century with the formation of the doctrine of informed consent, the relationship was rapidly transformed with the advent of the Internet, as well as the Food and Drug Administration’s (FDA) release in 1997 permitting direct-to-consumer-advertising (DTCA). Today’s Physicians must contend with two significant issues that simply did not exist in generations past. First, the Internet has both demystified the Doctor’s knowledge on a particular topic, as well as resulted in information saturation. Second, the direct consumer marketing of pharmaceuticals has resulted in more patient-driven demands for specific treatment/medications.



Increasing Internet use heightens patient involvement.

Patients regularly seek health information on the Internet regarding their health or medical condition. According to one study, nearly six million people a day search for medical advice on the Internet, which is more than the average number of people who actually set foot into a Physician's office.⁹ In fact, studies have found that between 74% to 90% of persons search for information to help understand their medical condition.¹⁰ A very telling statistic is the fact that Medline database searches increased from seven million in 1996 to 120 million in 1997, the first year that free public access was opened. The vast majority of Physicians (85%) likewise report that patients bring Internet information with them to an office visit.¹¹ Of the patients who have used the Internet to learn more about their symptoms, 45% have requested a specific treatment and 36% have suggested a specific diagnosis.¹² So as not to be blinded by statistics, what these studies demonstrate, in short, is that the vast majority of patients are Internet users and those patients are more likely to actively participate in shaping the course of their treatment with their Physician.

The advent of DTCA and its transformation of a patient to a consumer.

The FDA began permitting DTCA in the 1980s but significantly relaxed its requirements in 1997.¹³ In contrast to prior stringent requirements, pharmaceutical companies merely had to identify major side effects and contraindications in lay person's language. As a result, in the last 15 years, there has been a flood of direct-to-consumer marketing of medications, medical devices and even surgical procedures. Patients request and often insist on particular medical products after viewing these advertisements.¹⁴ Accordingly, patients today frequently attempt to diagnose themselves and decide on a course of treatment before even contacting their Physicians. Patients have become more than simple recipients of health care, they have become "consumers" of medical care: they share information online, discuss their experiences, rate Doctors, blog about treatment options, provide reviews of medications, etc. The impact of the DTCA cannot be understated; two decades ago, patients would rarely set foot into a Doctor's office demanding a precise drug for a condition (with which they had not even formally been diagnosed). The marketing of medications and treatment procedures has propelled a consumer mentality which now permeates health care.

The result: today's patient – an informed partner or a bully?

Without question, the practice of medicine has been profoundly impacted by the ease of access to information that was otherwise previously confined to those working in the health care community. On the positive side, patients are far more likely to actively participate in their medical care which leads to higher compliance and better health outcomes overall. On the negative side, patients can present to Physicians' offices with preconceived notions of not only their diagnosis, but their desired treatment course, which may conflict with the Physician's own beliefs, assessment and plan. Fortunately, studies demonstrate that the vast majority of patients today still heavily rely upon and trust the Physician's knowledge and expertise in determining their appropriate treatment plan. Therefore, the fact that a patient may walk into the office with a binder full of medical articles should not cause alarm or cause a Physician to instantly think "here comes a bully."



Bullying Defined

The distinction between an "involved patient" and a "bully" may be subtle, and it is important not to be too quick to lump interested and involved patients in the "bully" category merely because they suggest a medication about which they heard or read. Bullying is defined by the American Psychological Association as an aggressive behavior that is intended to cause distress or harm and that involves an imbalance of power or strength between the aggressor and the victim. It may be difficult to claim that any patient intends to cause distress or harm by demanding a specific treatment, but bullying is a method of acquiring power, and clearly the patient-bully wants to exercise control over his or her own treatment options (whether right or wrong). Bullies tend to consider others (in this case, their Physician) as existing only to serve them. These patients view Physicians' offices as a fast food drive-through, where



they arrive to “order what they want” without much regard to whether their Physician believes the order is right for them. Patient bullies tend to utilize Physicians as a necessary intermediary to acquire what they’ve already predetermined is indicated. While patient-bullies may comprise a modest percentage of the patient population as a whole, their demands often result in increased time and expense for the Physician’s practice. Physicians are forced to spend more time trying to explain why the treatment, test or medication requested by the patient is not necessary or appropriate. Alternatively, Physicians feel forced to order studies or tests that are not truly indicated.

The “balance of power” element in the textbook definition of bully would historically seem to favor Physicians, as Physicians had almost exclusive hold over medical knowledge and information. Certain aspects of today’s health care industry, however, have caused a shift in the balance of power seemingly in favor of patients. Financial and administrative pressures create an atmosphere in which Physicians feel pressured to acquiesce to patients’ requests, in order to ensure patient satisfaction and “return customers.”

Physicians may fear the backlash from a lawsuit if a patient’s desires are not met. The prevalence of malpractice lawsuits has made it very hard for Physicians to say no to patients. When debating whether “to test or not to test” or “to drug or not to drug,” Physicians may be inclined to opt for the desires of the patients to stave off potential litigation. The Congressional Office of Technology Assessment has defined this as “defensive medicine” – the practice of medicine that involves either the avoidance of high-risk patients or procedures or alternatively, the (unnecessary) ordering of tests, procedures or medications to reduce exposure to malpractice liability.

Defensive medicine may be most prevalent when encountering the patient-bully. When determining which treatment plan to implement, it would be only natural for a Physician to have a fleeting thought of the potential lawsuit if he or she refused the medication or procedure requested by the patient, and something untoward occurred in the aftermath. It may seem like a small leap for a patient-bully to become a malpractice plaintiff. Doctors need to be mindful, however, that the converse is just as likely: if an untoward event occurred in the aftermath of prescribing a drug that was not indicated, seeing the inside of a courtroom in a malpractice lawsuit is equally as likely. Therefore, while the fear of malpractice should cause Phy-

sicians to document thoroughly (i.e., defensively), that fear should not drive the treatment course for the patient.

From a time-management perspective, it may seem more time-efficient to acquiesce to a patient’s request rather than get into a lengthy discussion about why an alternative would be preferred. For these reasons, there may be a tendency for Physicians to cede some control over treatment decisions to patients. Such capitulation may not result in the better health of the patient, however, and could put the patient at increased risk. Utilizing the scenario from page one of this newsletter, the Physician’s acceptance of the patient’s self-diagnosis of hypothyroidism not only distracts the Physician from other possible sources of the patient’s fatigue, weight gain and joint pain, but the potential consequences of the medication itself may be overlooked.

Using the Existing Informed Consent Doctrine to Handle Bullies

Doctors must address patient bullying through effective communication, documentation and structured informed consent protocols. In this manner, the patient’s safety can be ensured concomitantly with preservation of the Doctor’s judgment, which has been honed with education, training and experience.



The American Medical Association, American College of Critical Care and the American Academy of Pediatrics, among other institutions, advocate use of the “shared decision making” (SDM) principle which is defined as “an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preference.” To apply SDM to practice, information is shared with the patient, patients are encouraged to deliberate on the options, and ultimately, to express their preferences.¹⁵ The goal of SDM is to ensure “informed preferences” so that decisions will be better understood, based upon more accurate expectations about



the negative and positive consequences and resultantly, are more consistent with personal preferences.

Sound familiar? This is what is known in the medical-legal community as the doctrine of informed consent, which imposes upon a Physician the duty to explain the procedure to the patient, and discuss the material risks, benefits and alternatives, so as to enable the patient to make an intelligent and informed choice about whether to undergo such treatment. The doctrine of informed consent provides patients with a legal cause of action against a Physician akin to medical malpractice; if a Physician fails to provide informed consent, that Physician can be held liable for damages associated with the treatment. Accordingly, it is within the construct of SDM or informed consent, that Physicians can find direction and guidance in managing the patient-bullies.

While there is general consensus about a patient's right to refuse unwanted care, controversy surrounds the issue of whether a patient can demand care that a Physician considers unnecessary. Utilizing the scenario from page one, the patient presented to a Physician's office and requested a medication for hypothyroidism, despite the fact that the TSH levels indicated subclinical hypothyroidism at best.¹⁶ Therefore, if the treatment or medication sought by a patient is contraindicated, then the Physician is obligated to refuse to provide that treatment. If the Physician's examination and assessment leads to the conclusion that a different diagnosis is far more likely, rendering the treatment sought to be unreasonable, then the Physician is similarly obligated to decline to provide the treatment sought by the patient-bully. A Physician is not required to acquiesce to inappropriate or unreasonable treatment demands. Given the various state and federal laws regarding who may prescribe medications and/or access controlled substances, it is clear that society has made a collective decision not to permit unfettered access to medications and treatment unless or until a Physician determines they are medically appropriate or reasonably indicated. If a Physician does not feel comfortable with the treatment or medication requested by the patient, then the Physician should refuse to provide the treatment and either (a) request a second opinion or (b) refer the patient to a specialist for guidance.

In short, the treatment sought must not be contraindicated or unreasonable under the circumstances. In circumstances where there is no contraindication, and there are some indications upon which the treatment can be deemed rea-



sonable, (even if not the Physician's optimal choice), then the Physician and patient must engage in an informed consent discussion, aka shared decision making.

During the informed consent discussion, the Physician should clearly identify the alternatives to the treatment proposed and require the patient to acknowledge that all reasonable alternatives were discussed with the patient. The material risks and benefits of the treatment should also be discussed, and the patient should be required to acknowledge his or her understanding of the risks. Finally, close follow-up should be recommended so that the Physician has the opportunity to monitor the treatment implemented to ensure that it remains a reasonable, if not optimal, plan for the patient.

So long as (a) ordering the drug is not contraindicated based on the patient's medical history or other factors, and (b) the Physician, exercising his or her independent judgment, believes the medication proposed may be reasonably likely to be effective, then the Physician may (but is not required to) acquiesce and order the requested medication.

Regardless of the ultimate treatment decision by the Physician, a thorough documentation of the informed consent discussion must be completed. For example, the Physician should document the fact that the patient came in requesting a certain medication/treatment; that the patient advised that they had done their own research on the medication/treatment; that the lengthy informed consent discussion was had with the patient regarding risks, benefits and alternatives (including conservative options), all of which were acknowledged by the patient; the fact that the patient opted for the medication in the aftermath of this discussion; the fact that the medication was not contraindicated and finally, the fact that the Physician believed it was a reasonable option available to address the patient's concerns. In short, the documentation should reflect that shared decision making occurred and an informed discus-



CME Evaluation Form

Statement of Educational Purpose

Doctors RX is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.[®] Its mission and educational purpose is to identify current health care related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:

- 1) Gain information on topics of particular importance to them as Physicians,
- 2) Assess the newsletter's value to them as practicing Physicians, and
- 3) Assess how this information may influence their own practices.

CME Objectives for "Informed Patient or Bully? A Doctor's Dilemma"

Educational Objectives: Upon completion of this enduring material, participants will be better able to:

- 1) Identify the differences between an informed patient and a bullying patient,
- 2) Understand the connection between informed consent and shared decision making, and
- 3) Utilize risk management recommendations when discussing treatment choices with patients.

Strongly Agree		Strongly Disagree
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Part 1. Educational Value:

5 4 3 2 1

I learned something new that was important.

I verified some important information.

I plan to seek more information on this topic.

This information is likely to have an impact on my practice.

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

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CME Test Questions

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CME Accreditation Statement – MEDICAL MUTUAL Liability Insurance Society of Maryland, which is affiliated with Professionals Advocate® Insurance Company, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians.

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Instructions – to receive credit, please follow these steps:

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3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the *Doctors RX*.

To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.

4. Completion Deadline: August 31, 2013

5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you.

1. Adoption of the doctrine of informed consent, advent of the internet, and the FDA's release in 1997 permitting direct-to-consumer-advertising have all contributed to the migration from a paternalistic to patient-centered Doctor-Patient relationship.
A. True B. False
2. The doctrine of informed consent requires Physicians to completely defer to a patient's wishes.
A. True B. False
3. A patient's active participation in his or her own medical care should be discouraged by his or her Physician.
A. True B. False
4. Treating a patient-bully results in increased time and expense for Physicians, who are forced to spend more time trying to explain the appropriate course of treatment and often feel forced to order studies or tests that are not truly indicated.
A. True B. False
5. The best way to prevent patient bullying is to acquiesce to a patient's demands.
A. True B. False
6. The American Medical Association, American College of Critical Care and the American Academy of Pediatrics all advocate the use of the "shared decision making" (SDM) principles.
A. True B. False
7. Applying SDM principles requires the Physician to share information with the patient, and encourage the patient to deliberate and express preferences regarding treatment options.
A. True B. False
8. A Physician must acquiesce and order the medication requested by the patient so long as (a) ordering the drug is not contraindicated based on the patient's medical history and other factors, and (b) the Physician, exercising his or her independent judgment, believes the medication proposed may be reasonably likely to be effective.
A. True B. False
9. One way by which physicians can protect themselves from malpractice lawsuits is by thorough documentation, to include notations reflecting that: (a) "shared decision making" occurred, (b) an informed discussion was had, and (c) the Physician obtained the patient's full consent.
A. True B. False
10. If patient bullying continues after a Physician's refusal to acquiesce to a patient's treatment requests, and the Physician has (a) documents the basis for refusal, (b) offers the patient regular follow-up to monitor the situation, and (c) provides an alternative treatment or a second opinion, then that Physician may terminate the Doctor-Patient relationship in accordance with local/state guidelines as well as the AMA's Code of Medical Ethics, Opinion 8.115.
A. True B. False



sion was had, leading to the patient's full consent. By thoroughly documenting the patient's own research, knowledge and request for treatment, as well as the Physician's lengthy discussion with the patient about the requested treatment, Physicians can utilize the wealth of information available to patients as a shield of sorts. Through the process of shared decision making, Physicians and patients (including the bullies) can usually find a workable balance.

However, there may be occasions in which a Physician finds himself in the unenviable position of having to refuse treatment to a patient. In those circumstances, it is equally important to document the basis for the refusal to implement the treatment requested by the patient. While the Physician should maintain his or her position, the patient should be offered regular follow-up to monitor the situation, an alternative treatment or a second opinion. If the bullying continues to the point that the Physician no longer feels comfortable managing the care of the patient, the Physician should consider terminating the relationship in accordance with local/state guidelines as well as the AMA's Code of Medical Ethics, Opinion 8.115.¹⁷

Of equal importance is the manner in which the discussion between the Physician and the patient-bully occurs. Statistics continue to show that good communication leads to increased patient satisfaction, improved health outcomes and a decrease in lawsuits.¹⁸ In fact, studies have demonstrated the importance of direct human contact and communication in achieving good medical outcomes, which results in increases in patient satisfaction, but

decreases in health-related costs as well. Emotionally engaged Physicians tend to communicate more effectively,¹⁹ decreasing patient anxiety and diffusing otherwise potentially "hostile" situations – particularly when managing the patient-bully.

When discussing treatment desires of the patient, especially when those treatment desires would not be your first choice, it is important to consider the following recommendations: (a) Show empathy by acknowledging the patient's concerns and emotions; (b) Assess the patient's knowledge, as well as the quality of the source of that knowledge; (c) Assess what the patient wants and needs to know; (d) Take time: don't appear rushed and engage in a dialogue that encourages the patient to describe his or her complaints and concerns; and (e) Clarify the treatment options for the patient, as well as the risks/benefits of each.

It may seem impossible to squeeze more into an office visit, but today's Physicians will more regularly encounter the patient-bully, the patient-consumer, or the informed patient, all of whom present unique challenges to health care. Having an informed discussion with the patient, while exhibiting empathy for his or her concerns, and documenting that which transpired, will both benefit the patient and protect the Physician. The SDM and informed consent principles provide Physicians the foundation for managing the vast majority of patients who step foot into their offices.

Examples of Questions to Engage a Bully in an Informed Consent Discussion

"Before I can recommend a treatment, I need to have a better understanding of your condition and concerns. Please tell me more about your symptoms."

"I understand your concerns about _____; and I'd like to discuss with you the various options to address this condition, including the one you propose. Each has risks/benefits that you should understand before making a decision."

"The advertisements make a lot of medications seem attractive, but do not always divulge the circumstances where it may not be appropriate. Let me explain my reasoning, and then we can discuss your concerns and questions."

"I'd like to ensure that we are following up on your concerns regarding _____; please follow-up in three months' time, or less if symptoms worsen. We can re-evaluate your condition at that point, and see whether any improvements have occurred."



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 1. Giving the patient written notice, preferably by certified mail, return receipt requested;
 2. Providing the patient with a brief explanation for terminating the relationship (this should be a valid reason, for instance non-compliance, failure to keep appointments);
 3. Agreeing to continue to provide treatment and access to services for a reasonable period of time, such as 30 days, to allow a patient to secure care from another person (a Physician may want to extend the period for emergency services);
 4. Providing resources and/or recommendations to help a patient locate another Physician of like specialty; and
 5. Offering to transfer records to a newly-designated Physician upon signed patient authorization to do so.
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Doctors RX

Elizabeth A. Svoisky, J.D., *Editor*
Vice President - Risk Management

Dr. George S. Malouf, Jr., M.D., *Chair of the Board*
MEDICAL MUTUAL Liability Insurance Society of Maryland
Professionals Advocate® Insurance Company

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