

Asking Dr. MedLaw: Q&A: Consultations When On-Call

When I am on-call at my hospital, I often get consultation calls from residents at our affiliated hospital. When this happens, there is no request for me to come in to see the patient. What liability status does this put me in?

Providing a phone consultation that you know will be relied upon establishes a physician-patient relationship with the patient even if you never have any personal contact with them. If you are “expected” to do this by your own hospital, that also establishes the relationship through your contract with your own facility.

You therefore want to make sure that you document the interaction with the resident. If no formal record is kept at your hospital because the case is being handled at the other location, then you should keep your own on-call record.

Although it will not be part of the formal medical record, if it is made up of notes that are contemporaneous with your involvement in the cases at the other facility, and it is kept for all cases (not just the “risky” ones) it may be able to be presented as evidence if you are sued later as being a record that you kept as part of your normal course of conduct in your on-call work.

The notes you should keep should include:

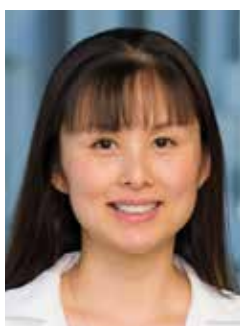
- The date and time that you were called about the patient
- The name and PGY status of the resident and any ID number for them
- The name of the patient and their medical record number
- A brief description of the discussion that you had with the resident, including the facts as presented by the resident, your diagnosis, and your recommendation(s) of actions to be taken.
- A statement that you instructed the resident to contact you if there were any significant changes and that the resident agreed to do so

Preferably do this on an electronic device because it is time and date stamped, and any additions will show up as separate addenda, all features supporting its reliability and making it more likely to be accepted into evidence should the need arise.

This article was written by Dr. MedLaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.



Examining CAM Disclosure in Patients With Cancer & Survivors



Contributor
Nina N. Sanford, MD
Assistant Professor,
Department of Radiation
Oncology
University of Texas
Southwestern

Complementary and alternative medicine (CAM)—therapies that are used in addition to or instead of conventional treatments—are frequently used by patients with cancer and cancer survivors in the United States, but there are growing concerns about its use. “A 2018 study found that patients using CAM were more likely to refuse additional conventional cancer treatments and die as a result, but the proportion of participants using CAM in that investigation was very low,” explains Nina N. Sanford, MD. “Data are needed to determine whether patients with cancer and survivors of the disease are disclosing use of CAM to their physicians and the reasons why they may not disclose this information.”

To address this issue, Dr. Sanford and colleagues had a research letter published in *JAMA Oncology*

that used data from the National Health Interview Survey (NHIS) to estimate the proportion of patients with cancer and cancer survivors who used CAM and analyze rates of CAM nondisclosure. In 2012, the NHIS included a supplement on CAM use. Data on CAM use and on patient demographics among those reporting a diagnosis of cancer were obtained through the Integrated Health Interview Series.

Highlighting Key Results

Among the more than 3,000 participants who reported a history of cancer, about one-third indicated that they used CAM in the past 12 months. The most commonly used CAM modality was herbal supplements (about 36%), followed by chiropractic or osteopathic manipulation (25%) and massage. Caucasian race, female sex, non-Hispanic ethnicity, and younger age were factors associated with a higher likelihood of CAM use.

“Importantly, nearly 30% of patients with cancer and cancer survivors who engaged in CAM did not disclose this information to their healthcare providers,” says Dr. Sanford. When the study cohort was restricted to patients with cancer who were diagnosed up to 2 years prior to taking the survey, about 33% reported using CAM and nearly 29% did not disclose CAM use to their physician (Table).

The study also examined reasons for not disclosing use of CAM. More than half of respondents reported that it was because their physician did not ask about using such treatments. Another 47% reported that they did not think their physicians needed to know they used CAM. Few CAM users reported feeling that their physician did not know much about CAM. “Most patients did not express concerns about a negative reaction from their physician for using CAM,” Dr. Sanford adds. Patients also did not commonly report being worried that their physician would discourage CAM use or that was discouraged in the past.

Assessing Implications

People with cancer and cancer survivors may have many motivations for seeking CAM. Some may wish to use it to manage persistent symptoms or psychological distress, while others seek to gain a sense of control over their care. According to Dr. Sanford, it is important for physicians to be proactive and ask patients about their CAM use. “A large proportion of patients will not openly disclose using CAM,” she says. “Patients need to be asked directly if they are using CAM and the types they use, because some CAM may be harmful. They also need to be given time and space to further discuss these treatments.”

Given the high proportion of patients with cancer and cancer survivors reporting use of CAM, further study is warranted. “In particular, robust studies are needed to understand the efficacy and toxicities of CAM therapies, particularly in combination with conventional cancer treatments,” says Dr. Sanford. “Analyses assessing costs and quality of life in patients who use CAM are also needed. Furthermore, research is necessary to better understand if using CAM is truly associated with refusal of conventional therapy and worse survival. The implications of CAM will likely depend on the specific modality used.”

Source: Adapted from: Sanford NN, et al. *JAMA Oncol*. 2019;5(5):735-737.

How Long Should Patients Fast Before Surgery?



Written by
Skeptical Scalpel

Clear liquids may be ingested for up to 2 hours before procedures requiring general anesthesia, regional anesthesia, or procedural sedation and analgesia.

A light meal or nonhuman milk may be ingested for up to 6 hours before elective procedures requiring general anesthesia, regional anesthesia, or procedural sedation and analgesia.

Having once had an encounter with an anesthesiologist who postponed a case because my patient had a piece of hard candy in her mouth, I wanted to see how closely that guideline was being followed since its publication 2 years ago. I posted a poll on Twitter. Although such polls are unscientific, over 3,800 people responded, and the results are thought-provoking:

What is your hospital's standard policy regarding oral intake prior to most operations? Patients may have clear liquids by mouth as follows:

- No limit before surgery: 2%
- Up to 2 hours before surgery: 29%
- Up to 6 hours before surgery: 22%
- NPO after midnight: 47%

Almost half of those participating said their hospitals were still mandating that patients take nothing by mouth after midnight. A number posted comments describing their experiences and frustrations.

Here's my favorite. “I once had a case canceled because the patient brushed their teeth in the a.m.” (I don't know about you, but I try not to swallow any toothpaste. Even if someone did swallow toothpaste, it is probably no more than a few milliliters of fluid.)

An anesthesiologist said, “The results of this poll are a little mind-boggling to me. (The ASA) guidelines dictate clears 2 hours before surgery is fine. How is the poll showing that patients have to be NPO for clears after midnight?”

In 2018, three European anesthesiology societies recommended a 1-hour fluid restriction for children undergoing anesthesia.

What is your hospital's policy? ■



Comparing Approaches to Oligometastatic NSCLC Management



Contributor
Daniel R. Gomez, MD
Associate Professor
Department of Radiation
Oncology
The University of Texas MD
Anderson Cancer Center

While it was previously thought that a subset of patients with limited metastatic disease could potentially achieve long-term survival, established approaches for treating patients with radiation therapy or surgery other than for palliative purposes were lacking prior to single-institutional data emerging over the past 10-15

years that suggest a survival benefit in selected patients when compared with historical controls treated with systemic therapy alone.

To confirm these data in a randomized manner, using progression-free survival as an endpoint, Daniel R. Gomez, MD, and colleagues designed a trial in which patients with oligometastatic lung cancer who did not progress after induction therapy were allocated to one of two treatment regimens in a 1:1 ratio: standard maintenance therapy/observation (MT/O) or aggressive radiation therapy/surgery, which the study team termed local consolidative therapy (LCT). “We tracked toxicity but our primary endpoint was progression free survival (PFS), with relevant secondary endpoints being overall survival and the time to development of new lesions,” explains Dr. Gomez, whose study results were published in the *Journal of Clinical Oncology*.

“Our study was closed early by our data safety monitoring board because we found a substantial benefit in PFS with LCT compared with standard care,” Dr. Gomez notes. Indeed, with an updated median follow-up of 38.8 months, the PFS benefit was 14.2 months, compared with 4.4 months with MT/O. The LCT group also experienced an overall survival benefit, with a median of 41.2 months, compared with 17.0 months in the MT/O group, as well as longer survival after progression (37.6 months vs 9.4 months). No additional grade 3 or greater toxicities were observed. Among patients in the MT/O group who experienced progression, nearly half received LCT to all lesions following progression and had a median overall survival of 17 months.

“I would view this data as provocative in demonstrating the benefit of LCT for patients with oligometastatic disease,” says Dr. Gomez. However, there are limitations that need to be taken into account when interpreting the data, primarily the small size of the trial, the heterogeneous population, and the fact that it was done in the pre-immunotherapy era. Future studies should attempt to expand on the existing data by addressing these constraints.”

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