

Asking Dr. MedLaw: Physician-Patient Privilege

Q: I am being sued for a claim of failed back surgery. The plaintiff had an IME by my side's doctor, and the complaints of pain were about what you would expect—hard to prove or disprove. However, the plaintiff mentioned to the doctor that she was "gonna get a hot car when I get a pile of money" from the case. I want the doctor to testify about this because it can really show the jury that this is a shake-down. The plaintiff is trying to block that. Can she do so?

A: The issue here is whether there is physician-patient privilege in this setting. Physician-patient privilege is a sub-set of this general stance on physician-patient confidentiality and refers to the ability of a patient to bar their doctor from testifying about them in a legal proceeding.

You did not say whether you are being sued in state or federal court, which matters, as the privilege is not recognized under the Federal Rules of Evidence. It may also be only allowed to a limited extent under the laws of your state.

However, let's just look at whether, assuming that it is potentially extant in the case, it could apply here.

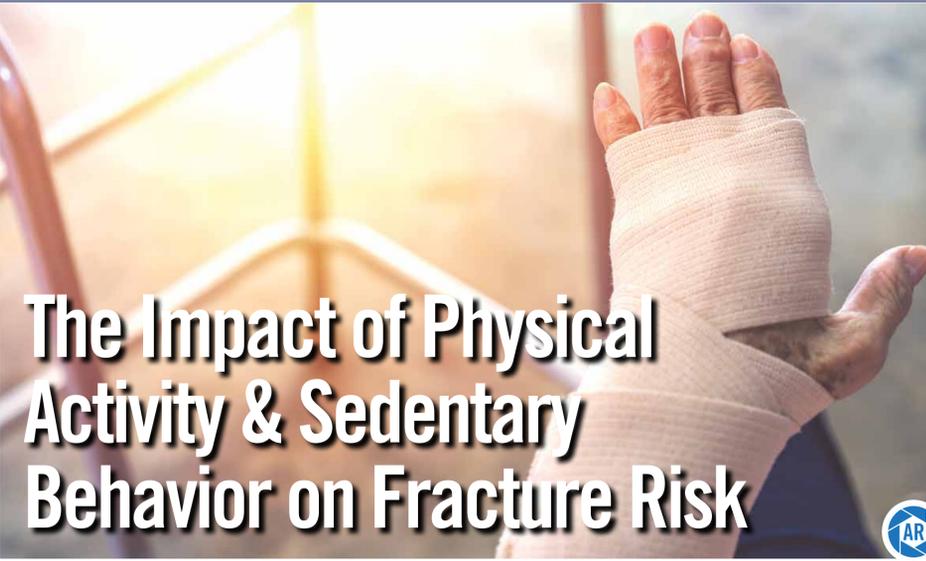
The critical point for it to apply is that the doctor whom the patient wants to restrain from speaking must have been the patient's, well, doctor, and here that is not the case. Not only was the plaintiff not seeking diagnosis or treatment from the doctor performing the IME, he was actually examining her for her adversary. The physician-patient relationship that underpins a duty of confidentiality and that gives rise to the privilege was completely absent.

Even if the plaintiff did not know the legal issues, she likely—since such are routine in IMEs—signed a form indicating that she understood that a physician-patient relationship was not created by the examination.

The plaintiff may try to get the judge to rule that this comment is "more prejudicial than probative"—in other words, that it will turn the jury against her more than it will add to a search for the truth—but that will truly be a last-ditch ploy to keep it out.

It is likely coming in.

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



The Impact of Physical Activity & Sedentary Behavior on Fracture Risk

Regular physical activity, including lighter-intensity activities, and less sedentary time appear to be associated with a lower risk of fracture in older postmenopausal women.



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Fracture risk in older adults depends on several factors, including the presence of osteoporosis or low bone mineral density, a propensity for falls, and decreases in muscle strength, balance, mobility, and physical functioning. "Considering the enormous public health burden of fractures, an emphasis has been placed on identifying modifiable risk factors that might be associated with lower fracture rates," says Michael J. LaMonte, PhD, MPH. "Identifying these factors could provide important clues for developing fracture prevention strategies for the aging population."

The Physical Activity Guidelines for Americans (PAGA), first published in 2008 and updated in 2018, suggest that greater amounts of recreational physical activity are associated with lower risks for hip and total fracture in older adults. "However, data are lacking on a possible relationship with fractures at other body sites," says Dr. LaMonte. To address this gap, Dr. LaMonte, Jean Wactawski-Wende, PhD,

and colleagues had a study published in *JAMA Network Open* that assessed the associations of physical activity and sedentary behavior with fracture incidence. The study used data from the Women's Health Initiative (WHI) and included more than 168,000 postmenopausal women aged 50 to 79 years.

Highlighting Key Findings

During a follow-up of 14 years, about one-third of the total patient population reported having a first incident fracture. "Greater participation in common activities of daily living—typically done at less than guideline-recommended amounts and intensities—were associated with statistically significant lower risks of hip and vertebral fractures," says Dr. LaMonte. "Likewise, walking 150 minutes/week or more was associated with a significantly lower risk of hip fracture when compared with no walking activity. These associations persisted after accounting for several risk factors for fracture, other types of physical activity, and the amount of daily sedentary time."

Participating in greater amounts of moderate-to-vigorous intensity activities (eg, jogging, heavy work activities, etc) was associated with a higher risk

of wrist and forearm fractures. "Women with enough functional capacity to engage in more intensive activity may be more prone to falls with an outstretched arm to brace themselves," says Dr. LaMonte. "This may increase their likelihood of a wrist or forearm fracture."

The study also explored associations between sedentary behavior and fracture risks. "Somewhat surprisingly, sedentary time was significantly associated with only total fracture risk," Dr. LaMonte says. "Women with the highest amounts of sitting (more than 9.5 hours/day) had a 4% higher risk of fracture compared with those with the lowest amounts of sitting (less than 6.5 hours/day)." When compared with women with the most sedentary time and no physical activity, fracture risk was lower in all other combinations of sedentary time and physical activity, even in women with the highest sedentary time who had increasing higher activity levels (Figure). More studies are needed to determine if sedentary behavior is an independent factor that predisposes women to fracture.

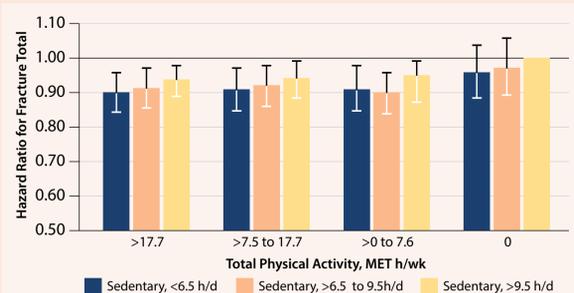
Assessing the Implications

The 2018 PAGA recommend that older adults avoid prolonged sedentary time; aim for at least 150 minutes/week in moderate-to-vigorous intensity aerobic physical activity; and participate in resistance exercise at least 1 to 2 times per week. Findings from the WHI study may be prominent in the section on bone health and fracture when the next PAGA update is published. "Older patients should be routinely assessed for the amount of time they spend doing various types of physical activity and how much time they spend in sedentary behavior, much like how we assess other important indicators of healthy aging, such as body weight or blood pressure," Dr. LaMonte says.

Older patients should be routinely assessed for physical activity and encouraged to be physically active by incorporating more movement into daily life activities, says Dr. LaMonte. "Simple things like walking around the home, doing household chores, and engaging in structured group exercise and resistance activities are good choices to recommend to older patients in their efforts to increase their physical activity." To be consistent with the current physical activity guidelines for public health, Dr. LaMonte suggests being vigilant in telling older patients to sit less and move more because every movement counts. ■

Figure Fracture Risk Based on Sedentary Behavior & Physical Activity Exposure

The figure below shows cross-classification of sedentary time and total physical activity in terms of total fracture.



Notes: Models are adjusted for age, race/ethnicity, education, smoking status, alcohol use, height, weight, history of fracture after age 55 years, bone drug use, corticosteroid use, calcium intake, vitamin D intake, lifetime hormone therapy use, falls in the past year, physical function construct, thiazide use, diabetes, age at menopause, and history of osteoporosis. The reference category was sedentary for more than 9.5 h/d and 0 metabolic equivalent (MET) hours per week of physical activity. Whiskers represent 95% confidence intervals.

Source: Adapted from: LaMonte MJ, et al. *JAMA Netw Open*. 2019;2(10):e1914084.

How Locum Tenens Can Help Your Permanent Job



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While locum tenens work is by nature temporary, it can also be helpful to those who want to remain in one place. How? Some use it to test out a new location or facility, where as others enjoy the extra income or the variety of experiences it can offer.

These four physicians have full-time jobs, but they've also discovered the advantages that locum tenens brings to both their practices and their lives:

Finding Your Place For those new to medicine, deciding where to start your career can be daunting. There is also pressure to accept the first offer that comes along, which is something that head and neck surgeon Dr. Kimberly Atiyeh felt acutely. "Toward the end of fellowship, I wasn't ready to make a decision about the next step," she says. After learning about locum tenens, she began working temporary assignments while continuing her permanent job search. "It really allowed me to relax and be patient in finding the right opportunity."

Getting a Sneak Peek For 35 years, Dr. Steven Berman worked as a general surgeon in private practice. While recovering from a surgery of his own, he decided to take leave from his permanent position and give locums a try. Over the next 6 years, he worked locums on and off, eventually taking an assignment in North Carolina. "I got to know the community, and the hospital got to know me," says Dr. Berman. He eventually was offered a full-time contract to work at the hospital, which he accepted. "It was certainly much easier to take a job knowing fully what that job was before committing."

Earning Extra Income "Because of the decrease in reimbursement and the increase in regulation by the government, it's hard to make a living in private practice," says Dr. Mark Kowalski, an orthopedic surgeon in Oklahoma City. This acknowledgement led him to consider working locums to earn some extra income, and he now accepts weekend assignments that are close to home. The additional income has helped Dr. Kowalski maintain his private practice; however, he's found that he enjoys locums so much that he says he may switch to locums work full time.

Learning from Others Dr. Demetri Poulis was looking for a way to relieve burnout after years of working on call—by himself—as a general surgeon. While exploring alternative career options, he discovered locums. He decided to spend some time traveling across the country, working in a variety of settings, and experiencing new ways of practicing medicine. "It let me see how it was done elsewhere, how other people handled things. I had more confidence in myself, especially after being burned out after that many years of being on call alone," he says. ■

In Case You Missed It

History of Falls Predicts Future Fractures in Postmenopausal Women

A history of falls, especially injurious falls, predicts subsequent fractures in postmenopausal women, according to a study recently published in *Osteoporosis International*. Researchers evaluated if a history of falls predicts future postmenopausal fractures and if this prediction varies according to the frequency, mechanism, and severity of falls or site of fractures. The analysis included 8,744 postmenopausal women (mean age, 62.2) surveyed at baseline in 1999 and again in 2004. Among participants, 19.4% reported a fall during the preceding 12 months at the baseline survey. Falls included 812 slip falls, 654 nonslips, 379 injurious falls, and 1,308 noninjurious falls. During follow-up, 811 women (9.3%) sustained a fracture; of these women, 431 had major osteoporotic fractures and 380 had other fractures. Earlier falls predicted subsequent fractures compared with nonfallers (odds ratio [OR], 1.41 [95% confidence interval (CI), 1.19 to 1.67; P < 0.001]; earlier slip falls: OR, 1.43 [95% CI, 1.14 to 1.80; P = 0.002]; earlier nonslip falls: OR, 1.35 [95% CI, 1.04 to 1.74; P = 0.02]). Future fractures were also predicted by earlier injurious falls (OR, 1.64; 95% CI, 1.21 to 2.23; P < 0.01), especially other fractures (OR, 1.86; 95% CI, 1.24 to 2.80; P < 0.01), but not major osteoporotic fractures (OR, 1.37; 95% CI, 0.89 to 2.10; P = 0.151). Earlier noninjurious falls increased the risk for future falls (OR, 1.36; 95% CI, 1.12 to 1.64; P = 0.002). Findings were similar even after adjusting for other factors. "These findings are relevant in improving screening and prevention strategies for fractures," the authors write.

Osteoporosis Severity Starts During Growth in Patients With SMID

The severity of osteoporosis in SMID started during the growth period and seems to be caused by a lack of an effective increase in bone mineral density, according to a study published in *Brain & Development*. Study investigators assessed the severity and pathology of osteoporosis in children and adults with severe motor and intellectual disabilities (SMID) by evaluating bone enzymes, by which they aimed to determine adequate treatment approaches for preventing fractures. Ninety patients (44 men, 46 women; mean age, 34.5) underwent bone-quality assessment. Quantitative ultrasonography (QUS) was used to measure the T-score and Z-score of the calcaneus, and blood tests were used to measure bone-specific alkaline phosphatase and tartrate-resistant acid phosphatase 5b levels as bone formation and resorption markers, as well as calcium, phosphorus, and parathyroid hormone levels as routine examination. Bone formation and resorption marker levels were within normal ranges in adults, although they were high during the growth period in children, adolescents and elderly women. Patients receiving tube feeding showed a significantly lower Z-score than those without tube feeding. Tube feeding was a significant factor for the Z-score, whereas age, vitamin supplements, and anti-epileptic drugs were not. "Any treatment should be started during the growth period," write the study authors, adding that "more study about tube feeding is needed." ■

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