



**MEDLAW**

## Dealing With Non-Compliant Patients: Avoiding Liability

The first step in avoiding liability due to patient non-compliance is identifying that the patient actually is non-compliant. Then, ask about the reason for it and do what you can to counter it. Your record must reflect your attempt to determine what correctable issues underlie the non-compliance and what steps you took to counter it. If non-compliance is not solvable as a single issue and verbal reminders are not fruitful, you can consider a treatment contract, which breaks the compliance into specific acts of patient cooperation that may be easier to follow. Your last option is an “at risk” letter that states the specific non-compliant acts and their clinical consequences. This can include the warning that a failure to correct the non-compliance will result in termination from the practice. You should not create a “decline” note in which the patient signs their refusal to comply. You would be retaining the patient in your practice despite being unable to treat them as you believe is proper.

Your records need to demonstrate that the patient is being non-compliant rather than just being ill-informed. Descriptions of the patient's non-compliant conduct should state the fact of the non-compliance undeniably but without condemnatory or self-serving language. But it should not be so removed as to become meaningless in convincing a reviewer that you are not an appropriate target or in closing off patient claims that you never said something you actually did.

When the therapeutic relationship is irrevocably broken down and it is necessary for you to step away because the patient is actually preventing you from practicing medicine properly, you will have to terminate them from your practice. You will then have to consider abandonment. If you are going to take the maximum step against someone who is already in opposition to you, do so carefully. Non-compliance leading to no option but termination is a gradual process by definition and so an evaluator will want to see that it was handled that way.

You should also consider stating the reason for the termination in a letter. The general rule is to not give a specific reason, but here stating “As we have discussed, and as outlined in the treatment contract that you agreed to, it was essential that you follow through on prescribed care. Due to your continued refusal to follow treatment guidelines, this practice will no longer be able to retain you as a patient as of (date)” may stop a retaliatory process before it starts.

*This article was written by Dr. Medlaw, a physician and medical malpractice attorney.*



*New research was presented at AHA 2020, the virtual American Heart Association Scientific Sessions 2020. The features below highlight some of the studies that emerged from the conference.*

## Silent Cardiovascular Disease Common in “Healthy” People

A study that screened more than 25,000 middle-aged people found that about one in 20 have serious coronary artery disease with at least one coronary vessel having at least a 50% stenosis. Overall, however, 42% of that same population have some form of measurable coronary artery disease. The researchers developed two prediction models. One can be performed at home and involves assessing risk factors and being able to do simple tasks such as waist circumference measurements. The other, more precise measurement, was dubbed the “clinical model” and would be performed at doctors’ clinics. Both models appeared to readily identify people who would benefit from further scanning. “We found that

30% of the people who scored the highest on the home model accounted for 67% of all the patients with disseminated coronary artery disease detected through CCTA,” said the presenting author. Of the 10,603 individuals determined to have some form of coronary artery disease, 1,502 had silent coronary disease with coronary arteries that were at least 50% stenosed. A 50% or greater stenosis was observed in one coronary artery in 1,072 patients, while 196 had 50% or greater stenosis in two coronary arteries and 49 had 50% or greater stenosis in three coronary arteries. Also, 35 individuals had blockages of 50% or greater in the critical left main artery. ■

## No Benefit for Omega-3 in STRENGTH Trial

A daily dose of a novel omega-3 carboxylic acid (EPA+DHA) compound did not reduce the risk of heart attacks, stroke, revascularization (stenting or bypass surgery), hospitalization for unstable angina, or cardiovascular (CV) death compared with a daily dose of corn oil, according to findings from the STRENGTH trial. The results stand in stark contrast to the positive results from the REDUCE-IT trial, which reported a reduction in cardiovascular events—including death—for icosapent ethyl, an EPA ethyl ester. One likely explanation can be found in the design of the two trials. The STRENGTH trial “deliberately chose corn oil as its comparator because it has a neutral effect on the clinical parameters, whereas mineral oil has a negative effect,” said the presenting author.

REDUCE-IT, as well as other earlier trials that demonstrated benefits of omega-3 compounds, used mineral oil. Additionally, “REDUCE-IT enrolled more patients with established CAD.” The STRENGTH trial recruited 13,078 statin-treated patients who were at high risk for CV events, with triglycerides 180-500 mg/dL, and HDL <42 mg/dL (men) or <47 mg/dL (women). Participants were randomized to 4 g of omega-3 CA or an identical corn oil placebo. The outcome for the combined efficacy endpoint was virtually the same between the groups, with a hazard ratio of 0.89. Looking at the primary prevention endpoint, the findings were also disappointing (HR, 1.16). Among patients with established CV disease, the HR was 0.94. ■

## Extra Imaging Helps Determine Cause in Women With MINOCA

An international, multicenter study to identify the cause of myocardial infarction with non-obstructive coronary arteries (MINOCA) found that, in a series of more than 300 women with MINOCA, additional diagnostic imaging was able to determine the underlying cause of their heart attack in 84% of the cases. In the study, women diagnosed with MINOCA received two additional imaging tests: optical coherence tomography and cardiac MRI. About 75% of the women with abnormal OCT or cardiac MRI had evidence of heart damage from reduced blood flow. Recently ruptured plaques were also identified, which had not been previously identified. In 21% of the women, cardiac MRI showed

myocarditis or another reason for heart dysfunction unrelated to artery blockage or blood clotting. For the remaining 16%, both OCT and MRI scans were normal, and the cause of the heart attack remained elusive. “Our findings demonstrate that even if the angiogram does not show substantial artery blockage, when women have symptoms and blood test findings consistent with a heart attack, it is likely a true heart attack and not heart inflammation,” said the presenting study author. “Additional imaging tests can get to the root of the problem and help health-care professionals make an accurate heart attack diagnosis for women and to ensure they receive timely treatment.” ■

## Clever Trial Design Gets Patients Back on Statins

For a study, patients who had previously quit taking a statin due to side effects were randomized to alternating 1-month periods of either 20 mg atorvastatin, placebo, or an empty pill bottle in a blinded fashion for 1 year. They performed daily symptom checks on a smartphone app. When provided with the data showing that their side effects while on placebo were as bad as those reported on statins, one-half of patients resumed their lipid-lowering statin treatment. Participants scored their symptom intensity on a 100-point scale using a smartphone app daily throughout the year. As expected, participants scored their mean symptom intensity higher when taking either placebo or the statin, as opposed to months without a pill (8.0 during no-pill months vs 15.4 on placebo and 16.3 on the statin). However, there was no significant difference between placebo and the statin. Pooling the results across patients, 90% of symptoms could be attributed to the nocebo effect (0.90 ratio of placebo-taking months vs no-pill months/statin-taking months vs no-pill months). ■

## Cardiovascular Disease Increased Mortality Risk in Patients With COVID-19

A study of nearly 30,000 patients with COVID-19 revealed that cardiovascular disease or risk factors for cardiovascular disease dramatically increased the risk of in-hospital mortality. The risk of death was particularly high for older, non-White men. The analysis utilized electronic health records from 54 health systems that use a COVID-19 database provided by health information technology firms Cerner and Amazon Web Services, which have made the database free of charge to researchers. The study team sought to understand who is most at risk, which is especially important for deploying immunization strategies. All hospitalized patients (n=28,299) had a positive COVID-19 lab test within 2 weeks of hospitalization. The median age was 52 years, 29.4% were Hispanic, and 47% were female. The results, measured from January to July 2020, showed that in-hospital mortality was 20.7% overall. However, among those for whom mechanical ventilation was required (32.6% of the hospitalized patients), the mortality rate was 74.6%. Mortality rates were 20.4% for patients with hypertension, 21.5% for those with diabetes, 28.8% for those with coronary artery disease, and 34.2% for those with heart failure. Hispanics had a lower risk rate for mortality (0.71) than all other races overall. ■

MEDPAGETODAY'S

**KevinMD.com**  
Social media's leading physician voice

## Is There Life After Medicine?

By Brian Rifkin, MD

My group of nephrologists is trying to convince our 75-year-old colleague to retire from full-time clinical practice. I think he truly believes that the day he retires, his essence will be forcibly removed from his body, and he will cease to exist. He has told me, more than once, that he will be dead in less than a year if he is forced to stop being a physician. I envisioned this type of machismo was very old-school thinking, but maybe not. Modern doctors strive for a better balance of work and life, but do you ever really stop being a physician?

We all have many titles in life. What happens when the title remains, but the interactions cease? I strive to add quality and not just quantity to the lives of my patients who need to start dialysis. I have type 1 diabetes and realize that their reality may someday be mine. I hope to retire young enough that I can still enjoy all life has to offer.

In nephrology, where we have not been filling fellowship training spots, we are failing to replace ourselves in the workforce. There will likely be a need for me to prolong my work life. When I think about stopping my medical practice, I think about the million ways to not do medicine: volunteering, teaching, reading, writing, relaxing, I love interacting and helping patients. I do not, however, always enjoy the structural, administrative, and financial barriers imposed by day-to-day practice. This has been my point to my senior partner; why not take the best parts of medicine and only do those things that add meaning and pleasure to your life?

But is my partner correct? Do we lose something when we retire? There is some evidence that waiting to retire may have some health benefits. In a 2019 Swedish study, it was suggested that working past age 65 was associated with better overall health, but one can certainly argue cause and effect in this type of observation. Not debatable is that the average age of American physicians is increasing. In a 2017 survey by CompHealth, doctors reported an average retirement age of 68 (vs 63 for all Americans), and only 32% said they looked forward to no longer working in medicine. Losing social interactions at work, feeling a loss of purpose, boredom, loneliness, and depression may provoke an identity crisis at the end of a physician's career.

The ideal retirement means something different for every physician. However, it is clear that the valuable skills we acquire afford the opportunity to contribute long into our golden years. I hope that when I am 75, I have the choice to contribute (or not) as I see fit. There is purpose in being a doctor. The trap is when you assume all that you are is a doctor.

*Brian Rifkin, MD, is a nephrologist.*

## In Case You Missed It COVID-19 Outcomes Not Improved With Convalescent Plasma

For adults with severe COVID-19 pneumonia, no significant differences are seen in clinical status or mortality for those receiving convalescent plasma versus placebo, according to a study published in the *New England Journal of Medicine*. Researchers randomly assigned hospitalized adult patients with severe COVID-19 pneumonia to receive either convalescent plasma or placebo in a 2:1 ratio (228 and 105 patients, respectively). The patients' clinical status 30 days after the intervention was measured on a 6-point ordinal scale ranging from total recovery to death. The study team observed no significant difference between the convalescent plasma and placebo groups in the distribution of clinical outcomes according to the ordinal scale at day 30 (odds ratio, 0.83). Overall mortality rates were 10.96% and 11.43% in the convalescent plasma and placebo groups, respectively, for a risk difference of -0.46%. At day 2 after the intervention, total SARS-CoV-2 antibody titers tended to be higher in the convalescent plasma group. The two groups reported similar adverse events and serious adverse events. “We believe the use of convalescent plasma as a standard of care in such patients should be reevaluated,” the authors write.

## Admission Hyperglycemia Predicts Mortality in COVID-19

Among noncritical hospitalized COVID-19 patients, admission hyperglycemia is an independent predictor of all-cause mortality, according to a study published in the *Annals of Medicine*. Investigators conducted a retrospective multicenter study involving 11,312 noncritical patients hospitalized with COVID-19 in Spain. Patients were classified according to admission blood glucose (BG) levels: <140, 140-180, and >180 mg/dL. Among participants, 18.9% had diabetes and 20.4% died during hospitalization. The in-hospital mortality rates were 15.7%, 33.7%, and 41.1% for BG <140, 140-180, and >180 mg/mL, respectively. Compared with patients with normoglycemia, those with hyperglycemia had a significantly higher cumulative probability of mortality, independent of preexisting diabetes. After adjustment for age, diabetes, hypertension, and other confounding variables, hyperglycemia was an independent risk factor for mortality (hazard ratios, 1.50 and 1.48, respectively, for BG >180 and 140-180 mg/dL). There were also associations noted for hyperglycemia with the requirement for mechanical ventilation, intensive care unit admission, and mortality. “Screening for hyperglycemia in patients without diabetes and early treatment should be mandatory in the management of patients hospitalized with COVID-19,” a co-author said in a statement. “Admission hyperglycemia should not be overlooked, but rather detected and appropriately treated to improve the outcomes of COVID-19 patients with and without diabetes.” ■