

## QA WITH DR. MEDLAW

### Physician-Patient Privilege

*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?*

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 IME's—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.*



## A Closer Look at Patterns in Prescription Opioid Use & Misuse Among Cancer Survivors

**Cancer survivors report higher rates of prescription opioid use than those without the disease, but this may not translate to increased opioid misuse. Caution against opioid misuse is warranted but should not come at the expense of effective pain management and improved quality of life for cancer survivors.**



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Recent reports have shown that about one-third of cancer survivors experience cancer-related pain, and prescription rates for opioids are higher for these patients than the general population. The American Cancer Society estimates that more than 17 million people in the United States were living with cancer in 2019, but this figure is predicted to jump to 22 million by 2030. These data highlight the growing need for healthcare professionals to optimize pain management, even in cancer survivors.

### A Comprehensive Analysis

Dr. Park and colleagues had a study published in *JAMA Open Network* that analyzed the prevalence of, and risk factors, for prescription opioid use and misuse in adult cancer survivors and compared patterns with those in people without cancer. Using data from nearly 170,000 respondents to the National Survey on Drug Use and Health, they assessed opioid use and misuse within the past 12 months in cancer survivors and in those without the disease.

For the study, survivors were divided into those with more recent cancer, which was defined as having had cancer within 12 months of being surveyed, and those with less recent cancer, which was defined as having had the disease more than 12 months prior to the survey. “Misuse was defined as using opioids in any way not directed by a physician in the past 12 months,” Dr. Park says.

### Highlights of Key Findings

Opioid use was higher for cancer survivors than for those without the disease, with more recent survivors reporting a nearly two-fold higher rate of use. However, rates of misuse were similar among more recent and less recent survivors as well as respondents without cancer (Table). “Even though patients with cancer were more likely to report using opioids than those without cancer, fewer than 5% reported misusing these therapies,” says Dr. Park.

Several factors were associated with prescription opioid use or misuse, including younger age, major depressive episodes, alcohol use disorder, and nonopioid drug use disorder. The findings

on age highlight the importance of screening younger individuals for potential opioid misuse, because they may experience long-term survivorship. The other aforementioned risk factors underscore the need to perform a thorough social history to identify underlying mental health or substance use disorders in patients suspected of opioid misuse.

The study also revealed that rates of prescription opioid use and misuse varied by cancer type. Patients with gallbladder, liver, pancreatic, larynx, windpipe, lung cancer, and cervical cancer reported the highest rates of opioid use, whereas those with prostate, testicular, or uterine cancer had the lowest rates. Prescription opioid misuse was highest in patients with esophagus, stomach, gallbladder, liver, or pancreatic cancer and lowest among those with breast cancer.

### Considering the Implications

“Given our findings, oncologists should be reassured that most of their patients with cancer are most likely using these prescribed medications appropriately,” says Dr. Park. “While clinicians should continue to exercise caution in not overprescribing opioids, we should not necessarily limit the prescribing of opioids if they are needed. The risk of opioid misuse appears relatively low among cancer survivors overall.”

According to Dr. Park, concerted efforts are needed to determine how recent legislation on opioids has affected access to prescriptions of these medications for cancer survivors. “We need to conduct more research to find the best balance between overprescribing and underprescribing opioid medications among patients with cancer,” he says.

### Table Analyses of Prescription Opioid Use or Misuse

The table below depicts unadjusted and adjusted analyses of prescription opioid use or misuse by reported cancer history.

Cancer History	Prescription Opioid Use		Prescription Opioid Misuse	
	Weighted %	Odds Ratio	Weighted %	Odds Ratio
No cancer history	30.5%	1 [Reference]	4.3%	1 [Reference]
More recent cancer history	54.3%	1.86	3.5%	1.27
Less recent cancer history	39.2%	1.18	3.0%	1.03

Source: Adapted from: Jairam V, et al. *JAMA Netw Open*. 2020;3(8):e2013605.

## In Case You Missed It

### Surgeon Skill Level Tied to Colon Cancer Surgery Survival

There is an association between surgical technical skill and long-term survival following colon cancer surgery, according to a research letter published in *JAMA Oncology*. Researchers recruited surgeons participating in the 2016 Illinois Surgical Quality Improvement Collaborative for a video-based technical skills assessment, with each surgeon submitting one representative video of a laparoscopic right hemicolectomy. Review was performed by 12 or more surgeons, including two colorectal surgeons with video evaluation experience. The National Cancer Database was used to identify patients who underwent any minimally invasive colectomy for stage I to III epithelial-origin colon cancer; patients with operations performed by participating surgeons were matched by National Provider Identifier numbers. Based on 609 patients who underwent laparoscopic colectomy at 11 hospitals performed by one of 15 participating surgeons, the researchers found that overall survival differed among skill tertiles (5-year survival: 79% for the high-skill tertile, 55% for the medium-skill tertile, and 60% for the low-skill tertile). Survival was improved for the high-skill versus low-skill tertile after adjusting for patient characteristics (hazard ratio [HR], 0.31). A higher likelihood of survival occurred with each 0.1-point skill score increment (HR, 0.90). The association between skill and outcomes was strongest among patients with stage II disease (high- vs low-skill tertile: HR, 0.14; medium- vs low-skill tertile: HR, 0.12). Among 307 open procedures, a survival advantage was seen with high-skill surgeons (HR, 0.41) and medium-skill surgeons (HR, 0.41) compared with the low-skill tertile. “Skill may affect survival through oncologic resection quality (eg, lymph node harvesting) or may reflect surgeon characteristics, such as operative volume or guideline adherence,” the authors write.

### Laparoscopic Resection May Be An Option for CRC Liver Metastases

For patients with metastatic colorectal cancer who have resectable liver metastases, survival outcomes at 5 years do not differ significantly for treatment with laparoscopic versus open liver resection, according to a study published in the *Annals of Internal Medicine*. Investigators examined long-term oncologic outcomes after laparoscopic versus open liver resection in a single-center trial involving 280 patients with resectable colorectal liver metastases. Patients were randomly assigned to either laparoscopic surgery (133 patients) or open surgery (147 patients). The rates of 5-year survival were 54% and 55% in the laparoscopic and open groups, respectively, at a median follow-up of 70 months (hazard ratio [HR], 0.93). In the laparoscopic and open groups, the rates of 5-year recurrence-free survival were 30% and 36%, respectively (HR, 1.09). “A limitation of our trial is that it was not powered to detect differences in secondary end points and was not designed to address a noninferiority hypothesis for survival outcomes,” the authors write. “Therefore, small-to-moderate differences in survival outcomes (in favor of either laparoscopic or open surgery) cannot be excluded, and clinicians should be aware of this when interpreting results.”

### DBT + Synthetic Mammography Better at Repeat Screening

At repeat screening, digital breast tomosynthesis plus synthetic mammography (DBT+SM) identifies more cancers than full-field digital mammography (FFDM), according to a study published in *Radiology*. Researchers conducted a prospective study involving 34,638 women screened with DBT+SM between April 2015 and March 2017 and rescreened with DBT+SM or FFDM (16,198 and 16,672, respectively) between April 2017 and March 2019. Screening performance was compared with that of 28,680 women screened with FFDM between 2013 and 2014 (controls). The cancer detection rate was higher for repeat screening with DBT+SM compared with controls (8.1 vs 4.5 per 1,000 women screened) and was similar for repeat screening with FFDM versus controls (3.5 vs 4.5 per 1,000 women screened). No difference was seen in the recall rate at repeat screening for DBT+SM (3.40 vs 3.71) and FFDM (3.69 vs 3.71) vs the control group; the positive predictive value of recall was higher with DBT+SM (23.8% vs 12.0%). The proportions of cancer that were stage II or higher were 14.5% and 8.5% with DBT+SM and FFDM, respectively, vs 27.3% in the control group. “The lower number of stage II or above cancers with the DBT plus synthetic mammography screening test demonstrates that DBT has the capability of anticipating the detection of cancers that might become advanced in the following 2 years,” a co-author said in a statement.

### Broader Genetic Testing Could ID More Heritable Cancers

Universal multigene panel testing for patients with solid tumor cancer increases detection of heritable variants over the predicted yield of guideline-based testing, according to a study published in *JAMA Oncology*. Study investigators assessed germline genetic alterations among 2,984 patients (mean age, 61.4; 53.0% male) with solid tumor cancer receiving care at Mayo Clinic cancer centers and a community practice between April 1, 2018, and March 31, 2020. A genetic analysis was conducted using an 80-gene next-generation sequencing platform. The researchers identified pathogenic germline variants (PGVs) in 13.3% of patients, including those in 282 moderate- and high-penetrance cancer susceptibility genes. Nearly one-half of patients had variants of uncertain significance (47.4%). Incremental clinically actionable findings that would not have been detected by phenotype or family history-based testing criteria were found in 6.4% of patients. Roughly one-quarter of patients (28.2%) with a high-penetrance PGV had modifications in their treatment based on the finding. PGV was associated with younger age at diagnosis. Only 17.6% of patients with PGVs had family members undergoing no-cost cascade family variant testing. “More than half of the patients who developed cancer due to inherited mutations were being missed, and that has major implications for family members,” a co-author said in a statement.

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