

QA WITH DR. MEDLAW

Patient Nonadherence With ER Follow-Up & On-Call Obligations

I take ER calls as a plastic surgeon. The ER doctor performs the primary repair on cases for which they determine don't warrant calling me and tells the patients to see me for follow-up. If the patient never calls, am I liable if they have a bad outcome?

The reliance of the ER doctor on your guidance and your understanding of this create a physician-patient relationship, even if the patient is unaware. The ER doctor is predicating their choice on the patient seeing you, an aspect of reliance. Under your privileges agreement or call contract, you have bound yourself to see anyone sent to you from that shift, which can also be held to underpin a duty to them.

There is also your contractual duty to the hospital as its agent. That you will see the patient for follow-up is baked into the process of the ER doctor doing the primary repair rather than bringing you in. Not doing so is a lapse in that process that the hospital could treat as a breach of your obligations.

You don't have a contractual duty to hunt a patient down and foist care on them, but you have to do what you reasonably can to fulfill the duties on which the hospital is relying. Ask the ER for a list, per shift, of every patient referred to you, and track who calls for an appointment. If a patient has not called within the clinical interval relevant to the case, send a letter (keep a copy) that includes the date, where and why they were seen, the procedure performed, the instruction they got to call your office for necessary follow-up, your urge to call you or a physician of choice for an appointment, and the importance of follow-up care in their recovery.

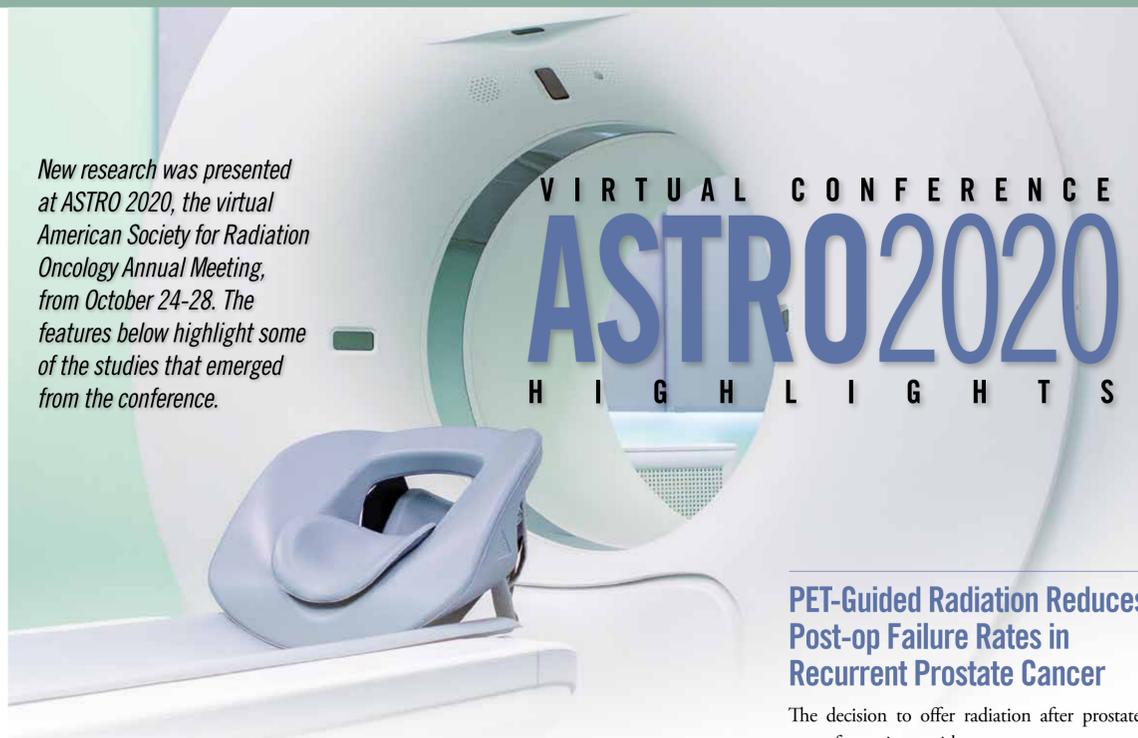
The inclusion that they were instructed to do this because it was necessary raises negligence on their part if they do not and fulfills your own duty to them. However, you have not done so in terms so strong that raise the issue of why you then did not go further. It would be the now-informed patient's choice of what to do.

If there is a serious risk involved in not seeing you for the follow-up and the letter does not get a prompt response, or if the patient needs to see you quickly but does not make an appointment within the needed timeframe, you will need to inform the ER that the patient never followed through and needs to be contacted through their official call-back system. Document that you did so, when, who you spoke with, and that they said they would handle it. You would not have to follow up further.

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



New research was presented at ASTRO 2020, the virtual American Society for Radiation Oncology Annual Meeting, from October 24-28. The features below highlight some of the studies that emerged from the conference.



Single Fraction an Effective Alternative to Multi-Fraction SBRT for Oligometastatic Lung Lesions

Evidence suggests that patients with cancer who have limited lung metastases may be suitable for surgery or stereotactic body radiotherapy (SBRT). For a study, researchers assigned patients with metastatic solid cancer and no more than three lung metastases in a 1:1 ratio to a single 28 Gy fraction of SBRT or 48 Gy over four fractions. Grade 3 or greater adverse events (AEs) at 1 year were experienced in 5% of patients in the single-fraction arm and 3% in the multi-fraction arm. Grade 3 AEs in the single-fraction arm included fatigue, chest pain, and loss of breath across two patients, with no fatal events, compared with one

patient who had undiagnosed interstitial lung disease and died of pneumonitis within 3 months of SBRT in the multi-fraction arm. Esophagitis and dermatitis were significantly more frequent in the multi-fraction arm, whereas all other common toxicities were not significantly different between the two arms. Local control rates were 93% in the single-fraction arm and 95% in the multi-fraction arm, while disease-free survival rates were 59% and 60%, respectively. Overall 1-year survival rates were 95% in the single-fraction arm and 93% in the multi-fraction arm. ■

Stereotactic Radiosurgery Bests Whole-Brain Radiation Therapy for "Numerous" Brain Metastases

Although previous studies support stereotactic radiosurgery (SRS) as the standard of care in patients with cancer with up to three brain metastases due to better preservation of cognitive function and similar overall survival when compared with whole-brain radiation therapy (WBRT), whether SRS should be used for the many patients who present with numerous (4-15) brain metastases remains unclear. Between 2012 and 2019, researchers randomized patients with four to 15 brain metastases to SRS or WBRT. At 4 months, patients in the SRS group had an average z-score increase of 0.21 from baseline on the Hopkins Verbal Learning Test-Revised Total

Recall, compared with a decline of 0.74 in the WBRT group. Patients in the SRS group also had statistically significant and clinically meaningful advantages in memory function over those in the WBRT group at 1 and 6 months. Overall survival in the intent-to-treat population was 7.8 months for those in the SRS arm, compared with 8.9 months in the WBRT arm. A clinically meaningful decline in cognitive function was experienced by 50% of the WBRT arm, compared with just 6% of the SRS arm. While 4-month local control rates favored SRS over WBRT (95% vs 87%), distant brain control rates favored WBRT over SRS (80% vs 60%). ■

Novel RT Approach for Cervical Cancer Achieves Similar Disease Control & Less GI Toxicity than Current Standard

Previous research showed improvement in patient-reported outcomes at 5 weeks and 1 year with intensity-modulated radiation therapy (IMRT) over conventional four-field pelvic irradiation in patients with cervical or endometrial cancer, but clarity on the long-term impacts of postoperative IMRT in this patient population is lacking. In hopes of providing clarity, study investigators randomized patients with cervical cancer treated with either type III hysterectomy with intermediate- or high-risk features or type I/II hysterectomy necessitating adjuvant chemoradiation

therapy to three-dimensional conformal radiation therapy (3D-CRT) or image-guided IMRT (IG-IMRT). Although disease control was similar in both groups, 4-year GI toxicity-free survival rates were 78% in the adjuvant IG-IMRT group and 57% in the 3D-CRT group. And while pelvic relapse-free survival rates did not differ significantly between the groups (IG-IMRT, 73%; 3D-CRT, 68%), grades 2 (hazard ratio [HR], 0.53) and 3 (HR, 0.23) GI toxicity rates were significantly reduced with IG-IMRT. ■

PET-Guided Radiation Reduces Post-op Failure Rates in Recurrent Prostate Cancer

The decision to offer radiation after prostatectomy for patients with recurrent prostate cancer has been shown to be complex, and significant limitations of conventional imaging leave a need for more accurate radiation therapy decision making and treatment planning. Although the advanced PET radiotracer fluciclovine was approved in 2016 for use with PET imaging to help diagnose recurrence in men with treated prostate cancer and rising PSA levels, it is not currently used for radiation treatment planning. To shed light in this area, researchers randomized patients with recurrent prostate adenocarcinoma post-prostatectomy 1:1 to radiotherapy based on standard imaging (controls) or radiotherapy based on standard imaging plus fluciclovine PET/CT (PET-guided). Failure-free survival rates at 3 years were 75.5% for those in the PET-guided group, compared with 63.0% in the control group; respective rates at 4 years were 75.5% and 51.2%. Grade 3 genitourinary adverse events were experienced by no patients in the PET-guided group and 3.7% in controls. Acute gastrointestinal toxicities were not observed in either group. ■

Most Cancer Survivors Experience Treatment-Related Sexual Side Effects

With the input of radiation oncologists, medical oncologists, and surgeons, researchers developed a questionnaire including more than 25 questions focused on experiences with sexual side effects after cancer treatment and distributed it to adults with mostly breast (67%), prostate (16%), and endometrial (6%) cancers treated with chemotherapy (78%), radiation therapy (54%), and/or hormone therapy (47%). Among respondents, 87% reported some change after cancer treatment that negatively affected their sexual function or desire, with 53.8% reporting body image distortion, 73.4% with dyspareunia, and 42.3% unable to achieve orgasm. However, only 27.9% said they had been formally asked by their clinician about their sexual health, and only about 40% said they had been preemptively warned that their treatment may affect their sexual health. "The majority of respondents felt that they would like a standard questionnaire to initiate and guide a discussion on sexual health with their provider," noted the presenting study author. ■

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Telemedicine Fatigue & the Stress of Remote Care

The first thing I heard from my team after starting fulltime telehealth was the exhaustion that seemed to set in at the end of the day. I have noticed this myself. After 8 hours of back-to-back virtual engagement with patients, I found myself with a kind of telemedicine fatigue that's hard to describe.

There are a few potential explanations for this almost consistent report among my colleagues who had transitioned to a full telehealth practice. I'm going to continue to dig deeper into this, but I suspect that it represents a couple of things.

Often, there are inconsistencies in connection, lighting, front-facing lens hygiene, and video quality that require a kind of on-the-fly compensation. And there are the parents who want to hold their phone at arm's length during a 30-minute consult, creating a simulated earthquake experience.

The most obvious potential contributor to this fatigue is the simple stress of transition. Adjusting to a completely different workflow is impossibly challenging, especially for health professionals who have been conducting analog care for most of their career. And on both ends of the encounter is the new "literacy" of engagement by live video connection. For example, the basic error of watching the screen display rather than the seeing-eye camera leads to a classic disjunctive virtual gaze that is subtly jarring and strangely distracting.

But the source of telemedicine fatigue goes beyond professional adjustment and correction of technical glitches.

I've identified that the emotional stress of subtly strained connection is a huge contributor to the exhaustion I feel. A video connection negates the subtleties of connection that are critical to my assessment of a parent and child. Identifying and exploring these subtleties is central to the care of chronically ill children and their families. It feels like I'm working hard to pick up on non-verbal cues that may be difficult to identify or simply out of the frame of view. The simultaneous observation of a mother and child in the same frame presents its own challenges in a home environment. I call this "drive by" telemedicine assessment, as the child zips in and out of the field of view grabbing toys, running for snacks, etc. ■

Visit 33charts.com to read the full article.



In Case You Missed It

Rurality, Income Impact Stage at Diagnosis, Mortality in Liver Cancer

Patients with hepatocellular carcinoma (HCC) from rural regions and lower-income households are more likely to have advanced-stage HCC at diagnosis and higher HCC mortality, according to a study published in *Cancer*. Researchers retrospectively examined adults with HCC using Surveillance, Epidemiology, and End Results data from 2004-2017 to update incidence and outcomes. For most groups, HCC incidence plateaued, except for American Indians/Alaska Natives (2004-2017: annual percentage change, 4.17%) and patients in the lowest household income category (<\$40,000; 2006-2017: annual percent change: 2.80%). Patients in more rural regions had increased odds of advanced-stage HCC at diagnosis (odds ratio, 1.10) and higher mortality (hazard ratio, 1.05) compared with those who had HCC in large metropolitan areas with a population >1 million. Patients with HCC who earned <\$40,000 annually had higher odds of advanced-stage HCC (odds ratio, 1.15) and higher mortality (hazard ratio, 1.23) compared with the highest-income group (≥\$70,000). "Our study highlights the need to focus on understanding the drivers of poor liver cancer outcomes among underserved and vulnerable populations, including those in rural geographic regions or among low income households," a coauthor said in a statement.

ASTRO Issues Guideline on Radiation Therapy for Rectal Cancer

In a clinical practice guideline issued by the American Society for Radiation Oncology, published in *Practical Radiation Oncology*, recommendations are presented for the use of radiotherapy (RT) for rectal cancer. The authors addressed four key questions focused on the use of RT in preoperative management of operable rectal cancer. Recommendations were based on a systematic literature review and were created using a predefined consensus-building methodology. According to the guideline, for patients with stage II to III rectal cancer, neoadjuvant RT is recommended, with either conventional fractionation with concurrent 5-fluorouracil or capecitabine or short-course RT. RT should be performed before rather than after surgery. In select patients with a lower risk for locoregional recurrence, omission of preoperative RT is conditionally recommended. There was also a conditional recommendation for the addition of chemotherapy before or after chemoradiation or after short-course RT. In select patients, nonoperative management is conditionally recommended if a clinical complete response is achieved after neoadjuvant treatment. Rectum and mesorectal, presacral, internal iliac, and obturator nodes are recommended to be included in the clinical treatment volume. In patients with tumors invading an anterior organ or structure, inclusion of external iliac nodes is conditionally recommended; in patients with tumors involving the anal canal, inclusion of inguinal and external iliac nodes is conditionally recommended. "This guideline focuses on providing options that can be tailored to patients' characteristics and their wishes," a coauthor said in a statement. ■