

[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.

LIABILITY

The Impact of Type 2 Diabetes on Colorectal Cancer Detection



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Type 2 diabetes appears to have an effect on adenoma detection rates for colorectal cancer (CRC), even after controlling for multiple variables. Early interventions to prevent and treat diabetes and to increase screening rates for CRC may improve patient outcomes.

According to recent estimates, colorectal cancer (CRC) ranks as the fourth most common cancer in the United States and the second most lethal. Colonoscopy screening has been considered the gold standard for CRC screening because it enables clinicians to view the entire colon and to detect and remove polyps during the same procedure to reduce subsequent risks of CRC. Despite the effectiveness of CRC screening, the American Cancer Society projects that more than 50,000 people in the US die annually from the disease.

“Beyond the established risk factors for CRC like advanced age, smoking, and a familial history of the disease, recent studies have suggested that people with diabetes have a higher risk of developing CRC when compared with those without the disease,” says Joshua D. Miller, MD, MPH. Studies have been conducted to address the association between diabetes and adenoma detection rate (ADR), but results from these clinical trials have been mixed. “We need a better understanding of the role of T2D in colorectal adenoma-carcinoma progression, since diabetes affects nearly 10% of the US population, or more than 33 million Americans,” adds Dr. Miller.

A New Analysis

For a study published in *Scientific Reports*, Dr. Miller and colleagues conducted a retrospective review of initial screening colonoscopies while attempting to control for confounding variables. In addition, the authors analyzed the effect of anti-diabetes medications and glycemic control as measured by fasting plasma glucose (FPG) on the day of the colonoscopy and within 12 months of the procedure. Of the 2,865 screening colonoscopies assessed in the study population, 282 were performed on patients who had diabetes. Of these, 9.8% had type 2 diabetes (T2D) and 2.4% had type 1 diabetes. Patients with diabetes were often treated with more than one medication.

“Our data showed that patients with diabetes had a significantly higher prevalence of adenomas and advanced adenomas than those without it,” Dr. Miller says. In a multivariable analysis, the study demonstrated that T2D was associated with an increased ADR (odds ratio [OR], 1.49), along with other factors, including smoking, older age, higher BMI, and male sex (Table).

T2D was not significantly associated with advanced ADR after taking multiple confounding variables into consideration. However, other factors were significantly associated with an increased advanced ADR, including older age, male sex, smoking, and increased BMI. For patients with T2D, those not taking diabetes medications were more likely to have an adenoma than those taking these therapies (OR, 2.38).

Assessing Implications

Results suggest that T2D is significantly associated with an increased risk of detecting at least one adenoma. In addition, two potentially modifiable variables were detected in increased BMI and smoking, both of which were significantly associated with increased ADR and advanced ADR.

“Early interventions for preventing T2D, attention to glycemic control, and prescribing medications that treat the disease and its secondary complications may reduce risks for developing colonic adenomas,” says Dr. Miller. “Such efforts may also

contribute to better CRC prevention. Clinicians should be aware of the association between diabetes and colorectal adenomas and perhaps recommend more frequent CRC screening in appropriate patients with diabetes. We should seize every opportunity to encourage patients to make lifestyle changes that can help reduce their risks for both CRC and diabetes.”

Of note, Dr. Miller and colleagues are conducting a prospective study in which patients with diabetes who are undergoing an initial screening colonoscopy will have their fasting insulin, C-peptide, and A1C levels measured prior to the procedure. “Our goal is to collect data on the biochemical components of diabetes and CRC,” says Dr. Miller. “We hope to establish the extent to which insulin resistance and/or hyperinsulinemia or other factors contribute to the increased risk of developing adenomas in a diverse patient group. This information may provide data on the specific pathways of diabetes and CRC progression and potentially help inform treatment decisions in the future.” ■

Table Key Comparisons

The table below depicts the adenoma detection rate (ADR) on initial screening colonoscopy performed on patients with type 2 diabetes and non-diabetes patients. It describes confounding factors associated with an increased risk of colonic neoplasia.

Variables	Levels	Odds Ratio
Type 2 Diabetes	Type 2 Diabetes vs Non-Diabetes	1.49
BMI	Every 1 Unit Increase in kg/m ²	1.02
Smoke	Current vs Never	1.44
	Current vs Quit	1.22
Age	Every 1-year Increase in Age	1.05
Sex	Male vs Female	1.96
Race	Black/AA vs White/EA	0.79
	Asian vs White/EA	1.12
	Other vs White/EA	0.86
Ethnicity	Hispanic vs Non-Hispanic	0.90
Family History of CRC	History vs No History	1.02
Aspirin Use	Yes vs No	0.94
Quality of Colonoscopic Prep	Good vs Excellent	1.31
	Fair vs Excellent	1.00
	Undocumented vs Excellent	1.01
Fellow Involvement	Yes vs No	0.94
Insurance	Commercial vs Medicare	1.21
	Commercial vs Medicaid	0.84
	Commercial vs Self-Pay	0.60

Abbreviations: AA, African ancestry; CRC, colorectal cancer; EA, European ancestry.

Source: Adapted from: Ottaviano LF, et al. *Sci Rep*. 2020;10(1):7193.

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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 as 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

Genetics Tied to Thromboembolism Risk With Inflammatory Bowel Disease

Genetic variants in some patients with inflammatory bowel disease (IBD) are associated with a significantly increased risk for developing thromboembolic disease (TED), according to a study published in *Gastroenterology*. Researchers used whole-exome sequencing and genome-wide genotyping to determine the proportion of 792 IBD patients genetically at risk for TED and investigate the effect of the genetic risk for TED in IBD. The researchers found that 122 of 792 IBD patients (15.4%) were genetically at high risk for TED. Among the 715 patients with documented TED status, 8.8% had TED events. There was a significant association between genetic TED risk and increased TED events (odds ratio [OR], 2.5). The investigators also observed an additive effect of monogenic and polygenic risk on TED. There was more frequent thrombosis at multiple sites seen among patients with high TED genetic risk (78% vs 42%; OR, 3.96). “Our results suggest that genetic traits identify approximately one in seven IBD patients who will experience 2.5-fold or greater risk for TED,” the study authors write.

Cirrhosis Cases Rising Among Women in North America

Cirrhosis disease burden in women has increased substantially since 2000, according to a study presented at The Liver Meeting, the 2020 annual meeting of the American Association for the Study of Liver Diseases. Study investigators used administrative healthcare data from Ontario to assess the contemporary epidemiology of cirrhosis and liver-related complications in women and projected cirrhosis disease burden to 2040. The analysis was based on data from 65,217 women who were followed for a median of 5 years. The median age at diagnosis was 57 years, with cirrhosis etiology most commonly resulting from nonalcoholic fatty liver disease (NAFLD; 63%), followed by alcohol-related liver disease (ALD; 16%), hepatitis C virus (HCV; 10%), autoimmune liver disease (AI; 6%), and hepatitis B virus (HBV; 5%). Incidence rates for cirrhosis increased by 33% (average annual percent change [AAPC], 2.5%). The changes in incidence rate were greatest for ALD among women born after 1980 (AAPC, 12.8%/year), followed by NAFLD among women born between 1945 and 1964 (AAPC, 8.4%/year). By 2040, the incidence rate for cirrhosis is expected to increase by 8% due to increases in ALD (+42%) and NAFLD (+34%); declines are expected in HCV (-91%), HBV (-225%), and AI/other (-179%). “Clearly, a heightened recognition of these key drivers of cirrhosis is essential for both primary care providers and specialists alike and should influence the development and evaluation of public health initiatives,” the presenting author said in a statement. ■

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