INSIDE RHEUM

Rheumatologist in the Headlights

"Doctor, I just know there is something else wrong besides my arthritis."

One of my regular patients was describing her severe thigh and groin pain. Nearby, her daughter was visibly concerned about her mother's pain and distress. I replied confidently that the patient's hip arthritis was severe enough to explain the pain. Maybe I was too cocky.

BY LARRY GREENBAUM, M.D.

But I went on. In the old days, I might have had to run around looking for her films, and then I could have made a great show by putting them up on a light box or holding them up to the fluorescent lights to prove my point. Now, thanks to the marvels of our computerized medical records and radiology system, I was easily able to pull up her hip radiographs from her previous visit 2 months earlier. I invited my little audience to take a look.

I pointed out the obliterated joint space and the various degenerative changes. This was the cause of the severe groin and thigh pain, I continued confidently. As I helped my hobbling patient back to her seat, I explained that the only great option in this situation would be a hip replacement. I never saw the hole I had just dug for myself.

The patient's daughter had not returned to her seat. In polite but firm terms, she asked why I hadn't done anything for the last 2 months if I knew that her mother needed a hip replacement?! How could I let the patient suffer for 2 solid months?

I felt like a rheumatologist in the headlights.

My brain whizzed through its memory archives as I tried to remember if there was documentation in the chart to prove I had already explained this option to the patient. Just as the crisis was at its tensest moment, out of the corner of the room came a small voice that was almost nonchalant, "Oh, he told me before." The daughter spun around and now her baleful stare was directed at her mother, who had undoubtedly been driving her crazy with this pain for weeks. I don't know what words they exchanged on the drive home, and it might have been interesting to be a fly on the dashboard, but I was glad to be spared.

I had another "unforgivable" moment early in my career. An older patient on hydroxychloroquine developed a pruritic drug rash that lasted longer than this sort of reaction usually does. Her itching continued for weeks after her skin cleared and was the dominant topic in several consecutive visits. At one tense moment, she glared at me and said, "If I had any idea that you knew this could happen to me, I'd never forgive you!"

Well, I was pretty sure I had warned her about this possible drug reaction, but what good was that? When we hand over a prescription, what small percentage of what we tell patients sinks in?

The only good thing to come out of this is that I think she forgot about her arthritis—or maybe she forgot to come back. Perhaps she is your patient now.

My most recent unforgivable incident occurred after I ordered an MR venogram for a patient with a painful leg condition. The hospital, thinking I had ordered a regular venogram, prepped the patient, started an IV, and parked him in the procedure suite. The radiologist hadn't performed this unpleasant procedure in ages, and he called me to confirm that this was what I really had ordered. The patient—who by now was in too much pain to hold still for the MRV and had to be sent home—construed this to mean that I was incompetent and that the radiologist had to explain the difference to me. Even after the hospital took the blame for the mix-up and threw in a complementary gasoline gift card to mollify him, the patient told my staff that he would never come back, in tones that were, according to the sticky note that my nurse left on my desk, "VERY angry." When I called him, he zinged a few choice expletives at me before he hung up.

I had only seen this patient once, but—sadly—the doctor-patient relationship is more fragile and more pressurized than ever before. It's a bit like working on the bomb squad: You get it right the first time or else.

Fortunately, I don't have to face such direct, in-your-face, patient hostility very frequently, but it is always memorable when it happens. I was aggravated for a week over that MRV mix-up.

The hospital should have sent me the gasoline card, but I forgive them. ■

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AMA Releases Health Insurer Code of Conduct

BY ALICIA AULT

Associate Editor, Practice Trends

The American Medical Association on May 25 called on U.S. health insurance companies to adopt its just-issued code of conduct.

The Health Insurer Code of Conduct Principles evolved out of a resolution put forward and unanimously adopted by the AMA House of Delegates at its 2008 Interim Meeting. The New York Delegation called on the AMA to develop such a code, get insurers to sign on, and come up with a way to monitor compliance. The code has already been endorsed by nearly every state medical society as well as 19 specialty societies, according to the AMA.

The last time the insurance industry issued any kind of internal standards was 15 years ago, according to the AMA.

"The health insurance industry has a crisis of credibility," Dr. J. James Rohack, AMA president, said in the statement. "With the enactment of federal health reform legislation, it's time for insurers to re-commit to patients' best interests and the fair business practices necessary to re-establish trust with the patient and physician communities."

Americas Health Insurance Plans, the industry trade organization, did not directly address the AMA code. But AHIP spokesman Robert Zirkelbach said that many of the principles are covered under the health reform law—formally, the Affordable Care Act.

"Health plans have pioneered innovative programs to reward quality, promote prevention and wellness, coordinate care for patients with chronic conditions, streamline administrative processes, and provide policyholders with greater peace of mind," Mr. Zirkelbach said.

"We will continue to work with policymakers and other health care stakeholders to improve the quality, safety, and efficiency of our health care system."

The code addresses topics including cancellations and recissions; medical loss ratios and calculating fair premiums; open access to care, including transparent rules on provider networks and benefit limitations; fairness in contract negotiations with physicians; medical necessity and who can define it; and a call for more administrative simplification, fewer restrictions on benefits, and better risk adjustment mechanisms for "physician profiling" systems. ■

The health insurance industry has a crisis of credibility and needs to recommit to fair business practices.

DR. ROHACK

For more information, visit www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/private-sector-advocacy/code-of-conduct-principles.shtml

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