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Wisconsin Medical Journal

Official publication of the Wisconsin Medical Society



COVER THEME

Self-Treatment:
With power comes
responsibility

Treating oneself, one's family and one's colleagues is an issue that certainly is not new to physicians, but one many have faced. Yet it is not often taught or even discussed. In this issue of the Wisconsin Medical Journal, 3 physicians discuss what is acceptable and what is not when it comes to this aspect of medicine.

Cover design by Mary Kay Adams-Edgette.

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

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A comprehensive journal, and the opportunity for discussion

John J. Frey, III, MD
Medical Editor, *Wisconsin Medical Journal*

A general journal should be general enough to include most areas of medicine. The *Wisconsin Medical Journal* is noteworthy because it covers the major clinical disciplines and includes information about the health of the public, important trends in chronic and acute illnesses, and occasional pieces such as that by Krall in this issue, which crosses all of the disciplines by raising important questions about professional behavior. Feedback from readers and authors are encouragingly showing us that we are going in the right direction by including something for everyone, but not so exclusively narrow as to render articles inaccessible. We are able to do this in great part because of the participation of authors—you think of the *Journal* for your work and write about what you do in an interesting and direct fashion. Thank you.

Two examples of good work that are helpful to colleagues are the 2 surgical articles in this month's *Journal*. Shapiro and colleagues (A Comparison of Open and Laparoscopic Techniques in Elective Resection for Diverticular Disease. *WMJ*. 107:6;287-291) describe a case series of laparoscopic resections for diverticular disease that highlight the positive benefits that this surgical approach offers. Their study, which was quite well done, uses sufficiently large numbers of cases to show that, on the whole, laparoscopic surgery saves patients

time in hospital, which most would be happy to avoid, and has similar outcomes in readmission and complication rates to traditional surgical approaches. I personally had a patient who was going to undergo surgery for diverticular disease and had been presented the option of laparoscopic approach. She wanted my opinion. Fortunately, this manuscript was in process and I could say with some authority that the data were pretty good and encouraged her to move ahead. The attraction of a shorter stay and quicker recovery was a real positive in her choice.

Stacey and colleagues' article (Exploring the Effect of the Referring General Surgeon's Attitudes on Breast Reconstruction Utilization. *WMJ*. 107:6;292-297) presents the case for a better dialogue between surgical specialties. Breast cancer continues to be a high visibility disease that is a concern for women and their families. Reconstructive surgery where possible offers many women the sense of comfort and self esteem that is an important component of recovery and moving back to a more normal life. In arguing for both performing mastectomies that would permit reconstructive surgery, and being in touch with plastic surgeons who perform them, Stacey and colleagues also suggest that we have more widely known standards about women who would benefit and those who would not.

Clearly there are women who are not candidates for reconstructive surgery post mastectomy. Primary care doctors, gynecologists, and surgeons providing consistent information for women who want the best advice for surgical management of breast cancer is essential. In a time of substantial emotional turmoil, women need to know the options open to them, and we need to work together to make those options clearer among the medical community.

Finally, as mentioned, the article by Krall (Doctors Who Doctor Self, Family, and Colleagues. *WMJ*. 107:6;279-284) and its accompanying commentaries should be a good source for discussion about the nature of self and family care. Physicians are notoriously difficult patients and the general press is full of books by and about doctors as patients. The bottom line is that doctors should have a doctor—and see them. Removing drug samples from offices has probably decreased the likelihood of self medication, but the tendency continues. What is acceptable and what is not should be a matter for discussion. Krall's article and the commentaries following it should be an excellent stimulus for conversations that need to take place among medical students, residents, and practicing groups. Whatever the outcomes of those discussions, we owe it to ourselves and our families to have them.

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Doctors Who Doctor Self, Family, and Colleagues

Edward J. Krall, MD

ABSTRACT

Treating one's self, treating one's family, being a physician-patient, and taking care of colleagues and their families are aspects of the practice of medicine that are not often taught or discussed in any type of venue. They are not new issues. They have been considered since the earliest days of medicine. They are sometimes controversial issues, since physicians have been reluctant to set standards for themselves. This article reviews the prevalence of physicians' treatment of self and their families and the problems that may arise, as well as the regulations that have been developed. It also examines the reluctance of physicians to seek care and the consequences and the special needs of physician-patients. Finally, guidelines for providing care to self and colleagues are suggested. Further education for students and house staff is needed to enable physicians to appreciate the risks of self treatment and to know how to best care for themselves and their colleagues.

INTRODUCTION

Physicians have been given the ability, experience, and power to wield the sword of medicine for others and can use their medical knowledge for their families and themselves. However, with power comes responsibility. How do they use this power? Do physicians usually prescribe medications for themselves or their family? Should they? What is ethically acceptable, and when does it become questionable?

This article will review the issues involved in physicians' care of themselves, their families, and their colleagues. It will further examine the complex problem of self-treatment, including its prevalence, the regulations that have been developed, and problems that tend to arise. Finally, some guidelines that have been developed in an attempt to address this issue will be reviewed.

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DISCUSSION

Prevalence

Self-prescribing and self-treatment among doctors is common and a pattern that is established early in their careers.¹ In the United States and Europe, from 52% to 90% of physicians report prescribing medications for themselves.¹⁻⁴

Taking medications from the sample closet was the most common source of self-prescribing, including 26% of all medications and 42% of all self-prescribed medications. Ten percent of all prescription medications were provided directly by pharmaceutical company representatives. A study with a family practice group reported 51 of 53 physicians, residents, nurses, and staff taking pharmaceutical samples for personal and family use.⁵

A longitudinal study of physicians followed during internship and the subsequent 9 years reported 54% of physicians in their fourth and ninth postgraduate years had self-prescribed at least once during the previous year.¹ Ninety percent of prescription medication during the previous year was self-prescribed, with the most common medications being antibiotics, allergy medicines, contraceptives, and hypnotics. Predictors for self-prescribing included being a male physician with somatic complaints and no primary care physician. Self-prescribing starts early in a physician's career. Efforts to develop a more formidable student assistance program should start in medical school.

When Physicians Treat their Own Families

Most physicians provide some level of care for their immediate family members.⁶ This may be no different than what most nonmedical parents or spouses would do—first try to take care of the problem themselves. Physicians, however, sometimes find it difficult to decide when their intervention is not in the best interests of the “patient.” Prescribing allergy medications or antibiotics is one thing, but what about surgery? Physicians admitted having attempted anything from cosmetic procedures like basal cell removal to abdominoplasty to C-section to pacemaker placement and angiography.

Convenience is most often cited as the reason for physicians to address a problem themselves, with confidence in their own diagnostic and treatment skills, concerns about quality of care, confidentiality, and cost also factoring into the decision.⁷

Data on families of physicians show that they were seen less often for acute illness, had incomplete exams, incomplete or absent medical records, and incomplete documentation of immunizations.⁸ Care of family members by colleagues was formerly seen as part of medical etiquette intended to permit physicians to avoid the difficulties involved in caring for one's relatives, but that practice is now passé and even considered fraud by some insurers.⁹ In fact, Medicare barred payment to physicians who provide care for immediate relatives effective November 13, 1989.

How Self-Treatment Is Regulated

In 1794, English physician Thomas Percival wrote the first code of conduct regarding physicians caring for themselves and their families in his book, *Medical Ethics*, which was to be used in resolving conflicts among physicians. It was published in 1804 with the subtitle, *A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*. It is of note that it was this work that served as the code of ethics for the newly formed American Medical Association (AMA) in 1845.

A passage of interest that is remarkable for its intuitive wisdom:

A physician afflicted with disease is usually an incompetent judge of his own case; and the natural anxiety, the solicitude which he experiences at the sickness of a wife, a child, or anyone who by ties of consanguinity is rendered peculiarly dear to him, tend to obscure his judgment, and produce timidity and irresolution in his practice. Under such circumstances medical men are peculiarly dependent upon each other, and kind offices and professional aid should always be cheerfully and gratuitously afforded.¹⁰

The AMA continued to adhere to this code through revisions up until 1957 when the AMA House of Delegates adopted an abbreviated code and omitted the references to treatment of family or professional courtesy, as does the current, even shorter, 1980 version.

In 1977, a comprehensive revision of its Opinions and Reports of the Judicial Council (now the Council on Ethical and Judicial Affairs) omitted all reference to the treatment of family, but retained what they called advisory guidelines to aid physicians in resolving ques-

tions related to professional courtesy. We are now left with this ethical guideline: "Physicians should generally not treat themselves or members of their immediate family."¹¹

Exceptions can be made for emergencies or in isolated instances when no other physician is available, but the AMA further opines that self-treatment raises questions regarding professional objectivity and the assurance of quality medical care.¹²

Each state has its own regulations, and there seems to be some misunderstanding among physicians as to what exactly is allowed under the law regarding self-care and prescription. More than 25 states now prohibit physicians from prescribing controlled substances for themselves or for their immediate families.

In Wisconsin, physician behavior is regulated by 2 sets of precepts. These are the state statutes and an administrative code that governs professional conduct. The state statute specifically prohibits physicians from prescribing themselves controlled substances.¹³

State of Wisconsin Statutes: 961.38 (5): No practitioner shall prescribe, orally, electronically or writing, or take without a prescription a controlled substance included in schedule I, II, III, or IV for the practitioner's own personal use.

The statute does not explicitly prohibit the prescription of such drugs for one's family. Therefore, it is legal to do so. However this must be done in the course of legitimate professional practice as stipulated in the Wisconsin Administrative Code.¹⁴ The code indicates that, in Wisconsin, you may prescribe medications and take care of your family but you must not do so outside the course of legitimate medical practice and you must keep a record. There are numerous examples of physicians being sanctioned by the Medical Examining Board, not because they administered care to family, but because they did not keep adequate records.

Where do we Draw the Line?

It can be argued that in emergencies or in the case of minor ailments, physicians could take care of matters for themselves as the AMA Code of Ethics suggests. However, the definition of a "minor ailment" may be controversial. Physicians have reportedly treated everything from hypertension to diabetes to mental disorders under the guise of minor ailments.¹⁵

Clear-cut rules or guidelines have not been established, and there is the question of the quality of care and objectivity. Some guidelines have been suggested, such as making allowances according to type of medication or indication.⁴ For example, perhaps it is reason-

able for a physician to self-prescribe medications for relatively straightforward conditions such as proton pump inhibitors for gastroesophageal reflux disease or antibiotics for minor infections, but not antidepressants for depression. It is inappropriate for a physician to self prescribe a beta-blocker for hypertension that would require monitoring, but acceptable if the same drug is used occasionally for stage fright for public speaking. In another situation, a physician should not initiate inhaled bronchodilators to treat asthma but it would be more acceptable if the same therapy was prescribed in the past by another physician if the condition is stable and monitoring is not required.

The question remains: is self-care good? There are no data on the quality of self-prescribed care. Previous research suggests that 29%-44% of physicians do not have a personal physician or seek regular medical care.^{3,16-17} Anecdotal accounts suggest that, although physicians as a group are healthy¹⁸ and have healthy lifestyles, their own health care is poor, in terms of their willingness to seek medical care. A longitudinal study of a class cohort of young doctors, first interviewed when they were students, showed that they suffer from frequent minor physical ailments, with women reporting more ailments than men. Despite this, they took fewer sick leaves and took little time off work. In addition, reported health behavior both in terms of response to illness over the past year, as well as predicted response to hypothetical illness, demonstrate maladaptive patterns including continuing to go to work when physically unfit, self-prescribing, and consulting friends and colleagues rather than going for a formal consultation.¹⁹

This may be especially inappropriate in cases of mental illness. Physicians have an increased prevalence of mental health problems, with the first postgraduate years being particularly stressful.²⁰ McCauliffe reported that 25% of 342 surveyed practicing physicians from New England had treated themselves with a psychotropic during the previous 12 months.²¹

It can be a slippery slope. Not all who self-medicate abuse medications, but many of those who abuse started by self-medicating. Compared with controls, physicians are 5 times as likely to take sedatives and minor tranquilizers without medical supervision.²²

In Finland, one of the most common reasons for physician self-medication was a mental disorder or insomnia.²³ When one looks at impaired professionals, self-prescription and abuse of addicting drugs were involved in 40%-75% of referrals to physician impairment programs.²⁴ Additionally, 20% of drug dependent doctors provided addicting drugs to spouses.²⁵

As other writers have observed, "Self-treatment is not to be viewed as simply a cause for physician impairment but as a symptom of poor health care for physicians."²⁶ The broader question remains, why don't physicians get their care from other physicians?

Physician Heal Thyself

Physicians may be no different than anyone else needing health care. It is a common sociological sequence across all cultures: when people need help for their medical condition, they first try to take care of it themselves, then ask the advice of friends, then try home remedies, and finally will seek help and make an appointment for a professional evaluation and care.²⁷

In choosing a provider, there may be concerns about age, gender, special interests, and style. There are issues of convenience, availability, geography, and cost. One may decide based on a friend or family's experience and recommendation.

Physicians often can and will bypass traditional care with informal care and consultations and choose a provider based on reputation, perception of competence, and/or a relationship with that person.^{3,28} Working relationships with other physicians may create barriers to privacy and make it difficult to identify a physician with whom one can comfortably assume the patient role. This type of behavior sometimes results in a somewhat deserving reputation of physicians being the worst patients.²⁹

Doctors Distorted Notions of Treatment

Busy schedules make it difficult for physicians to arrange time for self-care and to schedule appointments for themselves. They often use excuses like "I'm too busy," or "I can't get sick. There is no one else to take care of my patients."³⁰

Physicians, also, since medical school days, engage in self-diagnosis. They practice their own differential diagnostic thinking, and they are prone to "catastrophize," presuming that a twitch might be amyotrophic lateral sclerosis or an adenopathy can be cancerous. On the other hand, they can be in total denial: "There is nothing wrong with me; I don't need to see a doctor."³¹ This kind of presumptive thinking can lead to anxiety and avoidance of seeking care.

Physicians can be concerned about bothering their colleagues for what they presume might be trivial matters. They can be concerned about letting their partners down. If one's self-esteem is tied up in the role of being a doctor, it will be hard to surrender that role. Physicians can be compulsive and overly responsible. "Doctors don't get sick."³²

Other barriers to care include fear regarding

credentialing, licensing, or malpractice coverage. “What will happen if I admit I am depressed or have a drinking problem?”

Some physicians may not trust their colleagues. They may feel that they, themselves, can diagnose a condition, and feel that they are the “best person for the job.”

Then, there are the issues of role reversal. Physicians may not be accustomed to being a patient. There are the annoyances of delays in appointments, the inconvenience and unpleasantness of tests, and the embarrassment of seeing one’s patients in a waiting room.³³ They may have had a bad experience or not like how they were treated or be surprised by cost of care. It is surprising how many physicians are not aware of the limitations of the insurance coverage they have. Additionally, physicians are well aware of side effects and complications of treatment, which can lead to apprehension and avoidance of treatment.

Why Should I Have a Doctor?

Heroism becomes a way of life for physicians who try to work when they are sick¹⁵ and take on more than they can handle or have the myth of eternal youth and invulnerability. Often, they present late for treatment when they do present.³⁴

In spite of this, there are some good reasons for a physician to consider having a primary care provider:

- Knowing one’s limits—There are issues of competence, but in addition, depression, alcohol and drug issues, or fatigue can all affect motivation and judgment.
- An objective perspective—It is useful to have another’s opinion.
- Documentation—All too often care is not documented.
- Some things are hard to do—Exams like a pelvic pap, rectal, or prostate exam require another individual.
- Monitoring and follow-up of results—This needs to be a priority.
- Have an advocate—With insurance issues, administration and licensing, a knowledgeable resource to help navigate the system can be helpful.

Physician care becomes more important from another perspective when one considers Frank’s research, which demonstrates that the health habits of physicians influence the counseling they provide to their patients.³⁵ What is the message to patients if physicians avoid seeking health care for their own problems and prefer instead to manage these issues on their own? “Do as I say, not as I do?”³⁶

Caring for Colleagues Is an Art

If and when physicians do go to a colleague, there can

be associated problems. Professionals owe it to their colleagues to give them the best care possible, but there is no formal training in how to take care of a doctor and his family. It is all on-the-job-training and not always done well. Some providers are comfortable with their physician colleagues and develop a reputation for being a “doctor’s doctor” while others avoid it as an uncomfortable onus.³⁷ Some might feel pressured, strained, or insecure.

There are a number of important issues that must be considered when physicians care for colleagues. The caring physician may perform a perfunctory exam avoiding breast, rectal, or pelvic examination or avoid complete testing to include venereal disease research laboratory (VDRL), toxicology screens, or Human Immunodeficiency Virus evaluations. Caregivers may not completely explain things, assuming that the physician patient will know what the caregiver knows. Some may be tempted to do less rigorous follow-up, feeling that the patient would contact them if needed, or that they can obtain samples from the sample cabinet because it is a cost savings.

The VIP physician-patient syndrome has also been described.³⁸ Physicians uncomfortable with the patient role may expect special care with longer visits or visits outside of normal patient-seeing hours, or can be demanding by asking for a prescription or consult off the record, or second-guessing recommendations.

These factors can also affect care of physicians’ families. Spouses may be uncomfortable revealing problems with substance abuse or psychological problems for fear of embarrassment or breach of confidentiality. Sometimes physician relatives will intervene or second-guess treatment recommendations. Additionally the medical staff can be as apprehensive in caring for a spouse or family member as caring for a physician.³⁷

Guidelines

There are 2 major issues in taking care of fellow physicians and their families: treating them as colleagues and not treating them as colleagues.³⁹

Physicians should not take on these cases if they are uncomfortable. The relationship needs to be clarified from the outset. It should be collaborative as with all patients, but let the physician-patient be the patient with all the same rights and privileges. There is 1 person in charge, and that is the caregiver. The caring physicians need to treat the patients, stating from the outset that they will be as thorough in their history and physical and explanations as they are with any other patient. If it is too simplistic, it can always be modified, but the patient needs to know that their provider does not want

to compromise their evaluation. It's important to find the appropriate level of empathy and rapport, trying to be "not too chummy and not too distant."

On the other hand, when the patient is a physician or family member of a physician, a colleague should recognize that it might be difficult for him or her to ask for help. An effort needs to be made to dispel their anxiety. The patient should be assured he or she is not wasting time. Spending time listening to their professional concerns is reassuring. The provider should also ask for and listen to their self-diagnosis. Issues of privacy and confidentiality need to be discussed openly. Discuss the plan. If privacy concerns are a barrier, it may require a referral outside the system of care where they work.

For family members, the caregiving physician should deal directly with the patient and not go through the physician-relative. It's important to spend time alone with the patient. Questions of confidentiality should always be addressed, reassuring that nothing goes back to the spouse/parent/relative without their consent. Spouses and children may, sometimes, assume that physicians will talk with their colleagues, and it can compromise their ability to be honest. For follow-up, it should not be assumed that physician relatives will prescribe or order tests for their families.

Guideline for Treating your own Relatives

Providing medical care for your own family and relatives raises a number of ethical, emotional, and competency issues. There are times when it is more convenient, a matter of urgency, or accessibility, but when physicians starts to think they are the best person for the job, perhaps it is time to think again. Physicians from the earliest times purposely devised the custom of professional courtesy to avoid the ambiguities and discomfort of care for relatives.⁴⁰ That practice is now considered obsolete,⁴¹ but it would be prudent to heed this wisdom.

La Puma et al,⁶ who published one of the few empirical studies on these issues, suggested 7 questions that physicians who are asked to diagnose and/or treat family members should ask themselves:⁴²

1. Is the physician trained to meet his/her relative's medical needs? In other words, would the physician be seen as competent to care for this problem by an independent observer?
2. Is the physician too close? Family members may not wish to share issues with a physician relative. They may need that person to be emotionally involved and be the spouse or parent, not the detached clinical caregiver.

3. Can the physician be objective enough to not give too much, too little, or inappropriate care? With all the anguish that goes into seeing a loved one ill or with family conflicts, it is difficult to detach yourself.
4. Is medical involvement likely to provoke or intensify intrafamilial conflicts? Illness in a family may bring members closer together or push them apart. The caregiver needs to be able to separate him- or herself from those dynamics.
5. Familiarity can breed non-compliance. Sometimes family members are more likely to follow advice they are paying for.
6. Will the physician-relative allow the physician-provider to whom the relative is referred to attend the relative? A physician-relative can sabotage treatment with the best of intentions.
7. Is the physician willing to be accountable to his/her peers and to the public for this care? Accountability and liability have become very important in medicine. Care may seem acceptable if nothing goes wrong, but if complications and problems with the treatment ensue, it will be difficult to find supporters.

CONCLUSION

It is difficult to identify clear boundaries that separate inappropriate self-care from more acceptable examples. The culture of medicine is one where self-treatment starts early in physicians' careers, is not formally discussed, and perpetuates itself through training and practice. It is a discussion that needs to be heightened to a more formal venue; practicing physicians should evaluate their own self-treatment practices more closely.

Physicians should avail themselves of the excellent care and benefits they have available, secure a personal provider that they can trust and respect, and not attempt to care for their families or themselves. When colleagues do seek care, it is imperative that physicians be more attentive to the unique circumstances that may arise when taking care of doctors and their families.

More regulations are not needed. Instead, educational programs on self-prescribing and the special needs that arise in the care of colleagues should be developed for students and resident physicians.

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Editor's Note:

In light of the important issues discussed in Krall's article, the Wisconsin Medical Journal invited commentaries to help illustrate perspectives on the same topics from different physicians. Both Thomas C. Meyer, MD, and Leandra Lamberton, MD, were gracious enough to share their personal experiences and perspectives. Armed with a preliminary copy of Dr Krall's article, Dr Meyer and Dr Lamberton were asked to consider their own opinions about doctors treating themselves, family, and colleagues. They were also asked to consider how these opinions have changed and how their own experiences have effected these opinions.

Dr Meyer thoughtfully shares memories of treating his own children, along with his wife who was also physician, and how they both came to see the importance of this issue. Dr Lamberton shares her own, very personal experiences as the daughter of a physician, now a physician and mother herself, as well as her role as an adviser for young physicians walking the tightrope of self-treatment.

The two-physician family and the medical treatment of our children

Thomas Meyer, MD

"Dad did stick-ed me in the bot-ted" —Stephen, age 3, 1963

"My head is better, but why does it hurt when I bend my neck?"—Andrew, age 4, 1971

Plaudits to Edward, J. Krall, MD, and his incisive manuscript dealing with the thorny problems surrounding the diagnosis and management of one's own ailments and those of family, good friends, and, on occasion, neighbors. I wish that I had read it many years ago, for it contains wise advice for the unwary on how to handle these incidents.

In my experience, the 2-physician family complicates the issues in several ways—occasionally straining interpersonal relationships as well as escalating the anxiety when a child is ill and there is dispute as to the cause of the illness. With our son, Stephen, there was no dispute. He clearly had a recurrence of otitis media, which had previously been successfully treated by his pediatrician with a single shot of Bicillin (this was 1963). On the other hand, our son Andrew's headache and fever of 2 days duration had been the subject of intense debate for the 24 hours prior to his observation and precipitated an immediate visit to his pediatrician who confirmed his

nuchal rigidity. A spinal tap showed numerous lymphocytes in the fluid.

Stephen persuaded us that we were not appropriate people to administer unpleasant measures on one of our own and Andrew's encephalitis convinced us that neither of us was competent to diagnose our offspring's ills—both of us had examined him and missed the signs. After that, there was consensus that we would no longer attempt to be more than parents. The debates were frequently centered around which of us would be least inconvenienced by taking the child to an appointment. Selecting our own personal physician was, and still is, a decision that each made independently, and frequency of visits rests with each of us—and our respective physicians.

What is the role of a physician when there is illness in the family? Perhaps it is an important, if minor one, as an advisor and counselor. Who has better access to the resident staff to ascertain the comparative skills of one's surgical colleagues when surgery is necessary for a member of the family? It may be that service on the Credentials Committee has allowed insights not available to others. General support and explanation of the pathologies, therapies and courses of events is surely an important role, but Thomas Percival and Edward Krall, MD, are correct—illness in your own family is better dealt with by a truly objective observer.

Thomas C. Meyer, MD, is a retired pediatric cardiologist from Madison who served as Medical Editor of the *Wisconsin Medical Journal* for more than 10 years.

Lessons in objectivity: As a physician's daughter and now a physician mother

Leandrea Lamberton, MD

I have been surrounded by physicians treating themselves my entire life. My father was a physician, I am now a physician, and I work with medical students and residents who are struggling with the dilemmas of treating themselves. My thoughts have evolved over time, and I have made a very concerted effort to not repeat the pitfalls of my parents and to help others avoid or recover from pitfalls of self-treatment.

My father often diagnosed my siblings and me and prescribed treatment over the years. It was almost always outside the spectrum of his clinical expertise. Over time, as the idea of professional courtesy was fading out, my mother, who was not a physician, was horrified that she no longer could expect free care. Unfortunately, my father died suddenly and unexpectedly of a myocardial infarction the year before I started medical school. I am convinced that his self treatment and denial played a large role in his untimely death. With this lasting impression, I make a concerted effort to try not to repeat the mistake of failing to entrust my own health care to the hands of health professionals.

My decision to avoid self-treatment has only intensified over the years, especially because I am now a mother. A few years ago, my daughter was not feeling well in the middle of the night, and I gave her a dose of diphenhydramine for the first time. I knew how to properly dose it, but in my apprehension and concern for my own daughter, I looked it up in 2 different references and checked my calculations over and over before

giving it to her. After I gave her the dose, I was not able to fall back asleep because I was convinced that I had overdosed her. I had written orders so many times in the hospital for patients, but now the stakes were different, and I was second guessing myself. It became crystal clear that there was no way I could objectively treat my own child—and objectivity is essential to problem solving in medicine.

While self-treatment has obviously had an impact on my personal life, I also struggle watching it in my professional life. I have spent the last 3 years directing the mental health services for medical students and residents. In my direct clinical care of them, I see how much damage can be done when physicians in training self prescribe. I have seen many patients who have tried their own trial of antidepressants, anxiolytics, and hypnotics. They have underdosed, overdosed, and used them wrong, and this experience has at times made them leery of trying agents that could be helpful. It is impossible for them to tell objectively if they are better or worse—often resulting in the feeling that nothing will work. I spend a lot of time undoing the damage of their drug trials, which can prolong the time it takes for them to get better. I feel a large part of my role in treating them and advising them is to find health professionals these students and residents trust enough to allow the professional to provide treatment and break the self-prescribing cycle. It is not always easy to find such a situation, for a variety of internal and external reasons, but I am convinced time and time again that this is the best way for a medical professional to receive medical treatment.

Doctor Lamberton is an assistant professor of psychiatry and behavior medicine at the Medical College of Wisconsin, Milwaukee, Wis.

A Comparison of Open and Laparoscopic Techniques in Elective Resection for Diverticular Disease

Stephen B. Shapiro, MD, FACS; Pamela J. Lambert, RN; Michelle A. Mathiason, MS

ABSTRACT

Introduction: This study examines the outcomes of patients who underwent elective sigmoid resection for diverticular disease during the transition period from open to laparoscopic surgery.

Methods: The medical records of patients who underwent elective sigmoid resection from July 1, 1993 to June 30, 2005 at a community-based teaching hospital were retrospectively reviewed. Data collected included age, sex, duration of surgery, estimated blood loss (EBL), postoperative day of diet, length of stay (LOS), postoperative complication rate, and readmission rate. Data were compared using Wilcoxon rank sum and chi-square tests. Recurrence rates were evaluated.

Results: The medical records of 246 patients who had elective sigmoid resections were reviewed. One hundred sixty-six of the procedures were planned open operations, and 80 were initiated with laparoscopy. Of these 80 procedures, 10 were converted to open surgery. Overall, laparoscopic surgery was associated with shorter LOS (median: 4 days versus 8 days, $P < 0.001$; mean: 4.8 days versus 9.3 days), less EBL (median: 100 cc versus 200 cc, $P < 0.001$; mean: 167 cc versus 255 cc), and longer operative time (median: 185 minutes versus 153 minutes, $P < 0.001$; mean: 201.4 minutes versus 157.1 minutes). No mortalities occurred in either group. Readmission and recurrence rates were similar in the open and laparoscopic groups. Subset analyses to adjust for changes in practices over time did not account for improved LOS, EBL, or recurrence rate.

Conclusion: Compared with open surgery, laparoscopic surgery for elective sigmoid resection is associated with

a significantly shorter hospitalization and similar safety and recurrence rates.

BACKGROUND

Diverticular disease is an acquired condition that occurs frequently in industrialized countries. While it is uncommon in people under 40 years of age, nearly two-thirds of 80 year olds are affected.¹ No etiology is certain, but a diet high in fat and low in fiber is linked to formation of colonic diverticula.² For most people, diverticular disease is asymptomatic and will not lead to illness. It is estimated that 10%-20% will experience problems attributable to diverticular disease, such as bleeding, perforation, diverticulitis, stricture formation, or fistulization.³ Without treatment, the risk of recurrent episodes is approximately 45%.³ With elective sigmoid resection and primary intestinal anastomosis, the recurrence rate can be reduced to between 3% and 13%.^{4,5}

Redwine and Sharpe performed the first laparoscopic colon resection in 1990.⁵ In 1999, surgeons at Gundersen Lutheran Medical Center in La Crosse, Wis, introduced laparoscopic sigmoid colon surgery and currently initiate all elective sigmoid colectomies using this minimally invasive approach. Minimally invasive surgery is associated with less pain and a quicker recovery.⁶ This review evaluates our hypothesis that laparoscopic sigmoid colectomy can be adapted with safety and effectiveness comparable to that of open sigmoid colectomy and with shorter length of stay (LOS) and reduced blood loss, as reported in recent literature.⁷⁻¹²

METHODS

In this retrospective review, all patients who had sigmoid colectomies from July 1, 1993 through June 30, 2005 at a single community-based teaching hospital were identified by querying the electronic medical record database using a billing code specific to sigmoid colectomy. The medical records of these patients were further reviewed to identify the subset of patients who

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Table 1. Preoperative ASA Scores, Mean BMI, and Antibiotic Use Among 246 Patients Undergoing Laparoscopic or Open Elective Sigmoid Resection for Diverticular Disease

Surgical Technique	American Society of Anesthesiologists Score <i>P=0.005</i>				Mean BMI, kg/m ² <i>P=0.311</i>	Preoperative Antibiotic Use <i>P=0.546</i>
	1	2	3	4		
Open (%)	16 (9.6)	102 (61.4)	44 (26.5)	4 (2.4)	29.2	162 (97.7)
Laparoscopic (%)	9 (11.3)	64 (80.0)	7 (8.8)	0 (0.0)	29.9	79 (98.8)
Overall (%)	25 (10.2)	166 (67.5)	51 (20.7)	4 (1.6)	29.4	241 (98.0)

ASA=American Society of Anesthesiologists; BMI=body mass index.

underwent elective sigmoid resection for diverticular disease. The study period was chosen to coincide with 6 years prior to and 6 years after initiation of laparoscopic colon surgery at this medical center. Emergency sigmoid resections, resections for neoplastic disease, and left colon resections were excluded. Data collected included age, sex, body mass index (BMI), American Society of Anesthesiologists (ASA) score, preoperative antibiotic use, resident year in training, location of anastomosis, stapled or sewn anastomosis, duration of surgery, estimated blood loss (EBL), length of specimen, postoperative day of diet, oral analgesic doses, LOS, postoperative complications, mortality, and readmissions. Conversions from laparoscopic to open surgery were recorded. Recurrence was determined by review of the electronic medical record and from a simple patient questionnaire. LOS comparisons were adjusted by ASA score, age, and sex. Variables were compared using chi-square and Wilcoxon rank sum tests, with $P < 0.05$ considered significant.

Based on initial operative approach, cases were grouped as either laparoscopic or open. Cases converted from laparoscopic to open surgery were identified as laparoscopic to full open. A third type of procedure, hand access surgery, is an extension of minimally invasive surgery. A hand access device is a port that seals in pneumoperitoneum and allows the surgeon to slide a hand into the abdomen through a small incision in order to add tactile feedback to a minimally invasive procedure. The hand access incision is similarly sized to that required to remove the specimen in pure laparoscopic surgery and much smaller than that of full open laparoscopy. Hand access surgery and total laparoscopic surgery were grouped together in the laparoscopic arm. Under the supervision of the attending surgeon, surgery residents participated in the preoperative, operative, and postoperative care of all patients in the study.

RESULTS

Three hundred fifty sigmoid resections were identified from the electronic medical record database; 246

cases met study criteria. One hundred sixty-six sigmoid resections began as open surgery, and 80 began laparoscopically. There were 124 (51%) men and 122 (49%) women. Distribution of men and women in the open and laparoscopic groups was significantly different, with 75 (60.5%) men and 91 (74.6%) women having open procedures ($P=0.018$). Median age of patients in the laparoscopic arm was 55.5 years (range 39-92), compared with 63 years (range 28-81) in the open group ($P=0.005$).

Patient comorbidity as assessed by ASA score was significantly greater in the open group, as 29% of patients had ASA scores ≥ 3 versus 9% in the laparoscopic group ($P=0.005$). Neither BMI nor use of appropriate preoperative antibiotics was significantly different between groups (Table 1).

Intraoperative variables revealed similar rates of splenic flexure mobilization in the laparoscopic and open groups (54% versus 48%, $P=0.365$; Table 2). Median specimen length was shorter in the laparoscopic group, at 17.0 cm compared with 19.6 cm in the open group ($P < 0.001$).

No significant difference was identified in the rates of bleeding, enterotomy, or urinary tract injury when analyzed as single complications or when grouped as major complications, at 6.3% in the laparoscopic group and 7.8% in the open group. Mortality was 0 in both groups.

Laparoscopic surgery required significantly longer median operative time at 185 minutes compared with a median of 153 minutes for open surgery ($P < 0.001$). Mean operative times were 201.4 minutes for laparoscopic surgery versus 157.1 minutes for open procedures. Median EBL was less for laparoscopic surgery: 100 cc compared with 200 cc for open surgery ($P < 0.001$). Mean EBL values were 167 cc in the laparoscopic group versus 255 cc in the open group. Laparoscopic patients were more likely than open patients to have colorectal versus colosigmoidal anastomosis (laparoscopic=89%, open=72%, $P < 0.001$).

Postoperative variables are summarized in Table 3.

Table 2. Intraoperative Variables for 246 Patients Undergoing Laparoscopic or Open Elective Sigmoid Resection

Variable	Overall N=246	Open N=166	Laparoscopic N=80	P Value
Splenic flexure mobilization (%)	122 (49.6)	79 (47.6)	43 (53.8)	0.365
Ureter visualization (%)	159 (64.6)	101 (60.8)	58 (72.5)	0.073
Specimen length, cm ^a	18.0	19.6	17.0	<0.001
Major complications ^b (%)	18 (7.3)	13 (7.8)	5 (6.3)	0.656

^a Median value for specimen length reported.

^b Bleeding, enterotomy, urinary tract injury.

Table 3. Postoperative Outcomes for Patients Undergoing Laparoscopic or Open Elective Sigmoid Resection

Outcome	Overall (%) N=246	Open (%) N=166	Laparoscopic (%) N=80	P Value
Extent of disease, severe	159 (64.6)	116 (69.9)	43 (53.8)	0.013
Anastomotic leak	1 (0.4)	0 (0.0)	1 (1.3)	0.325
Readmission within 30 days	18 (7.3)	13 (7.8)	5 (6.3)	0.656

LOS was significantly reduced for laparoscopic sigmoid colectomies in a model adjusted by ASA score, age, and sex ($P < 0.001$). Mean LOS was 4.8 days in the laparoscopic group versus 9.3 days in the open group. Anastomotic leak rate was low overall (0.4%) and not significantly different between groups. Readmission within 30 days was required in 7.8% of patients following open surgery, versus 6.3% of patients treated laparoscopically ($P = 0.656$). Recurrence rates for diverticular disease were not significantly different between groups at 6.6% in the open group and 8.8% in the laparoscopic group ($P = 0.549$).

Thus far, data have been grouped and analyzed by the initial surgical approach employed. When the surgery began laparoscopically, it was completed that way 87.5% of the time. Compared with patients in the pure laparoscopic group, patients whose procedures were converted to open had greater median EBL during surgery (250 cc versus 100 cc, $P = 0.001$). Median LOS was significantly longer in those patients whose procedures were converted to open (6 days versus 4 days, $P = 0.012$). Initiation of diet was delayed after conversion to open (day 4 versus day 3, $P = 0.006$).

To consider differences in practice styles regarding LOS over the 12-year study period, we divided the groups into different eras. Between July 1993 and June 1999, all 111 patients underwent open resection with a median LOS of 9 days. During the second era (July 1999–June 2005), 55 patients underwent open resection with a median LOS of 7 days, and 70 patients had completely laparoscopic procedures with a median LOS of 4 days. The remaining 10 patients had open procedures converted from laparoscopic and had a median LOS of 6 days.

DISCUSSION

This study compares the outcomes of 246 consecutive patients undergoing diverticular surgery as we transitioned from an open to a laparoscopic approach. We believe this report supports our hypothesis that laparoscopic surgery can be completed as safely and effectively as traditional open surgery with outcomes comparable to those of other published series (Table 4). Compared with open surgery, laparoscopic surgery at our teaching institution between July 1993 and June 2005 was associated with slightly longer operative time, significantly shorter LOS, similar readmission rates, and comparable recurrence rates.

This study showed a dramatic reduction in LOS after laparoscopic surgery. Mean LOS in the laparoscopic group was 4.8 days. Other studies have reported an average LOS from 4 to 6 days following laparoscopic colon resection.⁷⁻¹¹ This series includes totally laparoscopic and hand-assisted laparoscopic surgery. Available reports, including prospective randomized trials, find similar outcomes with pure laparoscopic and hand-assisted laparoscopic surgery when analyzing LOS, operative time, return of bowel function, and complication rates.¹⁰⁻¹¹

Reduced EBL appears to be another benefit supported by this study and has been reported previously by Blake et al, Lee et al, and Noel et al.^{7-8,12} Through a systematic review of published reports in the world literature, Noel et al found that EBL for laparoscopic colon surgery for diverticular disease averaged 177 cc versus 313 cc for open surgery.¹² In this study, average EBL for the laparoscopic group was 167 cc.

Mean operative time with open colon resection averaged 157 minutes in this study, whereas the laparoscopic resection averaged 201 minutes. In this study, laparo-

Table 4. Benchmark Comparisons for Reported Open and Laparoscopic Operative Time, Length of Stay, and Estimated Blood Loss^a

Series	Operative Time, Min		Length of Stay, Days		Estimated Blood Loss, cc	
	Open	Laparoscopic	Open	Laparoscopic	Open	Laparoscopic
Gundersen Lutheran, N=246	157 ^b	201 ^b	9.3 ^b	4.8 ^b	255 ^b	167 ^b
Noel, ¹² N=11,910 ^c	142	191	9.6	5.5	313	177
Lee, ⁸ N=42	NA	197	NA	5.0	NA	200
Blake, ⁷ N=100	NA	196	NA	NA	NA	138
Lawrence, ⁹ N=270	140	170	9.1	4.1	NA	NA

NA=not available.

^a All values presented are means.

^b Comparison of open versus laparoscopic procedure results, $P < 0.001$.

^c Pooled results of a systematic review of 88 published studies.

scopic operative time is slightly longer than previous reports, which range from 170 to 197 minutes.^{7-9,12} Interestingly, operative time of open operations in this study was also slightly longer at 157 minutes versus the 142 minutes reported in the world literature summary by Noel et al. The authors believe this may be explained by the additional time necessary for medical education.

Anastomotic leak rate was low overall (0.4%), with 1 in the laparoscopic group and none in the open group. Leak rates reported by Noel et al were from 1.6% to 2.4%.¹² In a prospective multicenter study by Scheidbach and colleagues, the anastomotic leak rate was from 1.8% to 3.3%.¹³

A significantly greater percentage of women than men had open procedures. While there is no clinical evidence to account for this difference, a possible explanation is that women are more likely to have had prior pelvic surgeries, creating a higher incidence of adhesions requiring an open procedure. This study was designed to evaluate consecutive patients and did not focus on comparing the distribution of women and men in the open and laparoscopic groups.

The main purpose of elective sigmoid resection for diverticular disease is prevention of recurrent disease. This study reviewed electronic medical records and patient questionnaires that inquired whether the patient had experienced either a recurrence of their disease or a hernia at their wound site. A weakness of this approach is the lack of standardized, objective criteria by which to determine recurrence rates. In a review by the Cleveland Clinic Florida, rates of recurrent diverticulitis have been reported to be between 4% and 10%.¹⁴ With recognition of the limitations of the approach in this study, the recurrence rate of 8.8% using laparoscopic techniques compares favorably with benchmarks. Colorectal anastomosis has been important in reducing rates of recurrence. We report an 88% rate of stapled colorectal anastomosis in the laparoscopic group.

Since acceptance of the laparoscopic approach, surgeons in this medical center have initiated all elective sigmoid surgery with laparoscopy. The overall rate of conversion from laparoscopic surgery to open surgery was 12.5%, which compares favorably with the rates of 7% and 24% that others have previously reported.^{7,9-10,15-16} The subgroup of patients converted from laparoscopic to open surgery tended to be sicker, as gauged by ASA score. Only 9% of the patients in the laparoscopic group had ASA scores ≥ 3 , compared with 29% of the patients in the open group. Not surprisingly, patients with intraoperative hemorrhage requiring conversion to open elevated the mean EBL in the laparoscopic to open group from 140 cc to 345 cc. Severe adhesions from prior surgery and severe inflammation from advanced diverticular disease were other indications for conversion.

CONCLUSION

Surgeons at our institution have adopted laparoscopic sigmoid colectomy as the primary surgical approach for patients in need of elective sigmoid colectomy for diverticular disease. Compared with open surgery, laparoscopic sigmoid colectomy demonstrates a similar complication rate, a comparable recurrence rate, and a significant reduction in LOS.

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Exploring the Effect of the Referring General Surgeon's Attitudes on Breast Reconstruction Utilization

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ABSTRACT

Background: Breast reconstruction rates remain low, at 5%-15% of mastectomy patients, despite the safety and high patient satisfaction of these procedures. Reasons for this are multifactorial, including the attitudes and biases of the referring breast surgeon, as well as patient factors. The purpose of this study was to explore attitudes of general surgeons towards breast reconstruction.

Methods: We surveyed 369 general surgeons in Wisconsin with questions about breast surgery. Responses from 135 (36%) surgeons were analyzed.

Results: Seventy-three percent of the respondents performed at least some breast surgery and were eligible for the study. For a little over 50% of the general surgeons surveyed, breast surgery made up less than 10% of their practice. Fifty-one percent never performed a skin-sparing mastectomy. A large number of breast surgeons (40%) did not refer all mastectomy patients for reconstruction. Reasons cited for not referring patients included the concerns over cancer recurrence and advanced patient age. Reasons for patients not undergoing reconstruction included patient's refusal, need for radiation therapy, delaying adjuvant oncologic treatment, patient factors, and having no plastic surgeon available locally.

Conclusions: The decision by a patient to undergo breast reconstruction involves many complex factors. As a specialty, we should focus on improving the availability of breast reconstructive surgeons and educating referring surgeons and patients about reconstructive indications and options in order to positively affect the utilization of breast reconstruction.

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INTRODUCTION

The American Society of Plastic Surgeons reported that 56,176 patients underwent breast reconstructive procedures in 2006.¹ Despite the high number of patients undergoing reconstruction, breast reconstruction rates remain low, with only 5%-15% of eligible patients undergoing reconstruction.^{2,3} The reasons for this are complicated and multifactorial. In the United States, there are geographic differences in breast reconstruction rates,⁴ which could be due to differences in cultural values and access to health care. When they examined the Surveillance, Epidemiology, and End Results (SEER) database, Alderman et al found that Atlanta had a 33.6% immediate reconstruction rate compared to Hawaii's rate of 7.6%.³ Sociodemographic factors including age, race, patient income, and geographic location are also correlated with reconstruction rates.^{3,5} Clinical variables, such as stage of disease and need for adjuvant therapy, likely also effect reconstruction utilization.^{3,5}

Other studies have found that the referring general surgeon's biases and level of knowledge regarding reconstruction influence a patient's decision to undergo breast reconstruction.^{2,6-8} Additionally, there are likely other patient factors that influence the decision to choose breast reconstruction. Hawley et al found that patient factors and surgeon demographics accounted for 60% of between-surgeon variation in reconstruction referral.⁹

In the present study, we hypothesized that referring physician biases and recommendations influence whether a patient undergoes breast reconstruction. We set out to characterize and define these biases and examine subgroups of referring physicians.

METHODS

We surveyed 369 general surgeons in Wisconsin. The physician file was obtained from the American College of Surgeons as an electronic database. The survey was administered through the mail with a reminder postcard sent 1 month after the original mailing. No incentive gift for completion of the survey was offered. The sur-

vey contained 27 questions. Questions were asked about oncologic and reconstructive breast surgery as well as demographic information. A 5-point Likert scale was used for some questions (Strongly Agree to Strongly Disagree). Questions about percentages were left open-ended. Other questions were multiple choices and multiple answers, and included questions about referral and practice patterns. The surveyed general surgeons were given 6 statements that were either positive or negative regarding several aspects of breast reconstruction, and they were asked whether they agreed or disagreed with the statements. The survey was administered in January 2007. Specifically, we set out to examine ideas and opinions about breast reconstruction.

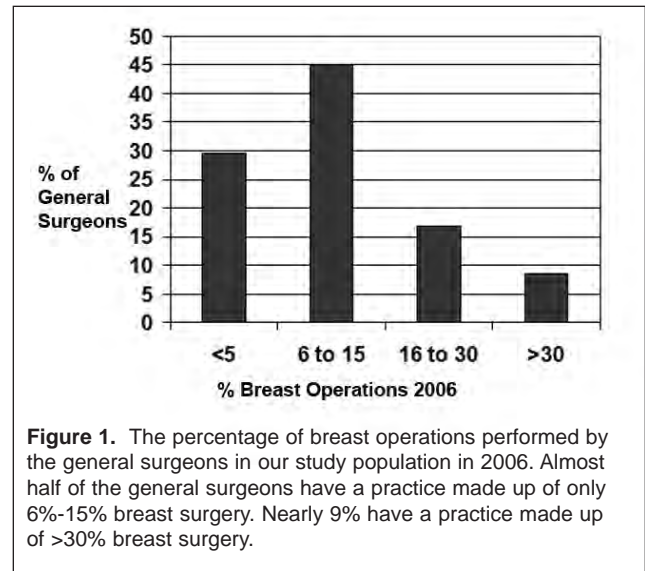
The survey was approved by the University of Wisconsin Health Sciences Internal Review Board and questions were developed in conjunction with the University of Wisconsin Comprehensive Cancer Center Survey Research Shared Service.

Data analysis was performed using R for Windows version 2.4.0. For subgroup analysis, a chi-squared test was done to look for significance between 2 groups. Urban surgeons were defined as surgeons who practice in the 3 largest urban areas of Wisconsin (Madison, Milwaukee, and Green Bay) and rural surgeons were the remaining surgeons. We also compared answers between surgeons who had been in practice <15 years and >15 years. These years were chosen as the cutoff because it split the study population approximately in half.

RESULTS

Responses were received from 135 (36%) of surgeons surveyed, with 84% male and 16% female. Seventy-four percent of respondents trained in an academic setting and 22% trained in a community program, while 4% trained in an "other" setting. Five percent of the surgeons received post-residency training in surgical oncology or breast oncology. Sixty-five percent of the respondents had been in practice >15 years.

Figure 1 shows the number of breast operations performed by our sample population in 2006. For a little over 50% of the general surgeons surveyed, breast surgery made up less than 10% of their practice. Interestingly, 51% of the surgeons never perform a skin-sparing mastectomy and 90% never perform a nipple-sparing mastectomy. A majority (74%) of these surgeons stated that they discuss breast reconstruction with all of their mastectomy patients, but a substantial number of surgeons (33%) do not routinely refer eligible patients to plastic surgeons to discuss breast reconstruction.



We examined factors affecting referral for breast reconstruction. Thirty-seven percent of respondents consider age to be a factor when deciding which patients to refer for breast reconstruction. Also, 44% refer only if there is a low chance of breast cancer recurrence. However, if the patient expresses concern about her own sexual image, then she is likely to be referred by 44% of respondents. The majority of general surgeons stated that the factors that we asked about (eg, age, patient's acceptance of mastectomy, patient's own sexual image, etc) made no difference on the decision to send a patient to a plastic surgeon.

Patient refusal was cited by surgeons as a common reason (62%) that patients do not get breast reconstruction. Other less common, but significant, reasons that patients are not being referred for breast reconstruction include delay in oncological treatment (18%), the patient will receive radiation therapy (19%), reconstruction was not offered (11%), and no plastic surgeon was available (6%).

A significant number of surgeons (17%) refer their patients to plastic surgeons after mastectomy. Patient deferral to see a plastic surgeon pre-mastectomy was the most common reason cited (42%). Other reasons for post-mastectomy referral include difficulty in coordinating immediate breast reconstruction with a plastic surgeon (18%), having no plastic surgeon available (17%), and need for radiation therapy (19%).

Forty-seven percent of respondents never refer a patient who has received a partial mastectomy, while 52% sometimes refer a patient to a plastic surgeon. Ninety percent of general surgeons surveyed never perform "onco-plastic" surgical procedures.

Table 1 summarizes the response data to several

Table 1. Statements Posed to General Surgeons in Wisconsin

Statement	Strongly Agree / Agree (%)	Neutral (%)	Disagree / Strongly Disagree (%)
Surgeons should pursue Breast Conservation Treatment rather than reconstruction.	68	33	9
Aesthetic results are worth monetary costs.	62	35	3
I am reluctant to damage healthy tissue.	5	9	86
Reconstruction imposes too high a burden.	0	9	91
Reconstruction may mask a local recurrence.	29	29	42
Reconstruction restores femininity.	74	25	2

statements. In response to the statement, “Breast reconstruction masks breast cancer local recurrences,” 29% of surgeons agreed with the statement and 29% were neutral on this statement.

Subgroup analysis was performed to examine differences between surgeons who had been in practice less than and more than 15 years, and between urban and rural surgeons. Urban surgeons in this population are more likely to consider the patient’s income status (urban=29% versus rural=0%, $P<0.05$) and the patient’s age (urban=14% versus rural=0%, $P<0.05$) as factors in determining whether they would refer the patient to a plastic surgeon (Figure 2). Conversely, rural surgeons were more likely to consider if the patient had comorbidities (urban=29% versus rural=44%, $P<0.05$). Also, rural surgeons were more likely to only refer patients if the chance of recurrence is low (urban=47% versus rural=0%, $P<0.05$). No difference existed between urban and rural surgeons with regard to considering health insurance, as most respondents answered “Makes No Difference” (urban=100% versus rural=87%, $P=0.33$). Both groups considered the patient’s acceptance of the mastectomy (urban=50% versus rural=44%, $P=0.24$) and life expectancy (urban=39% versus rural=47% $P=0.08$) as significant factors.

Surgeons who had been in practice <15 years were more likely to agree with the statement, “I am reluctant to damage a healthy part of a woman’s body for breast reconstruction” (14% versus 0%, $P<0.05$) than surgeons in practice >15 years. No other significant differences were found when comparing answers from surgeons in the practice-length groups.

DISCUSSION

A large number of the respondents in our survey (74%) said they routinely discuss breast reconstruction with all of their patients. This number is higher than in a nationwide study performed in Japan in which only 23% of surgeons “usually” gave breast reconstruction material to their patients.² Obviously, the discussion will be different with every patient and knowing what informa-

tion is specifically discussed is outside the scope of this study. What we can infer is that there are a large number of potential breast reconstruction patients who are not referred to plastic surgeons, as evidenced by the fact that 33% of general surgeons do not refer all eligible patients. Either the surgeon does not offer the referral to the patient or the patient refuses it once it is recommended. Patient refusal was cited by 62% of surgeons as the primary reason there was no immediate breast reconstruction. Alderman et al found similar results in a study of breast surgeons in which 57% believed that reconstruction is “not important to patients.”⁷ It is easy to understand that surgeon biases and the way the information is presented can affect the patient’s decision to accept the referral.

In the study cited above, the authors performed a similar analysis of breast surgeon attitudes and how they affected referral to plastic surgeons.⁷ They found that high referral surgeons were more likely to be women, to have high clinical breast surgery volume, and to work in cancer centers.⁷

A significant number of surgeons (17%) surveyed only refer patients post-mastectomy, even though the results with immediate breast reconstruction are safe, effective, and give excellent aesthetic results.¹⁰⁻¹¹ There is also a psychological benefit for the patient who receives an immediate reconstruction.¹²

Other reasons cited for post-mastectomy referral included difficulty coordinating a 2-team approach with a plastic surgeon (18%) and having no plastic surgeon available for referral (11%). This may represent the views of rural surgeons who do not have access to plastic surgeons. Improving plastic surgeon’s scheduling flexibility may better serve the reconstructive needs of patients.

Post-mastectomy radiation therapy (PMRT) indications have broadened in the last few years.¹³⁻¹⁴ In this study, respondents cited “need for radiation therapy” as a reason for not referring patients for reconstruction 19% of the time. The usage of PMRT

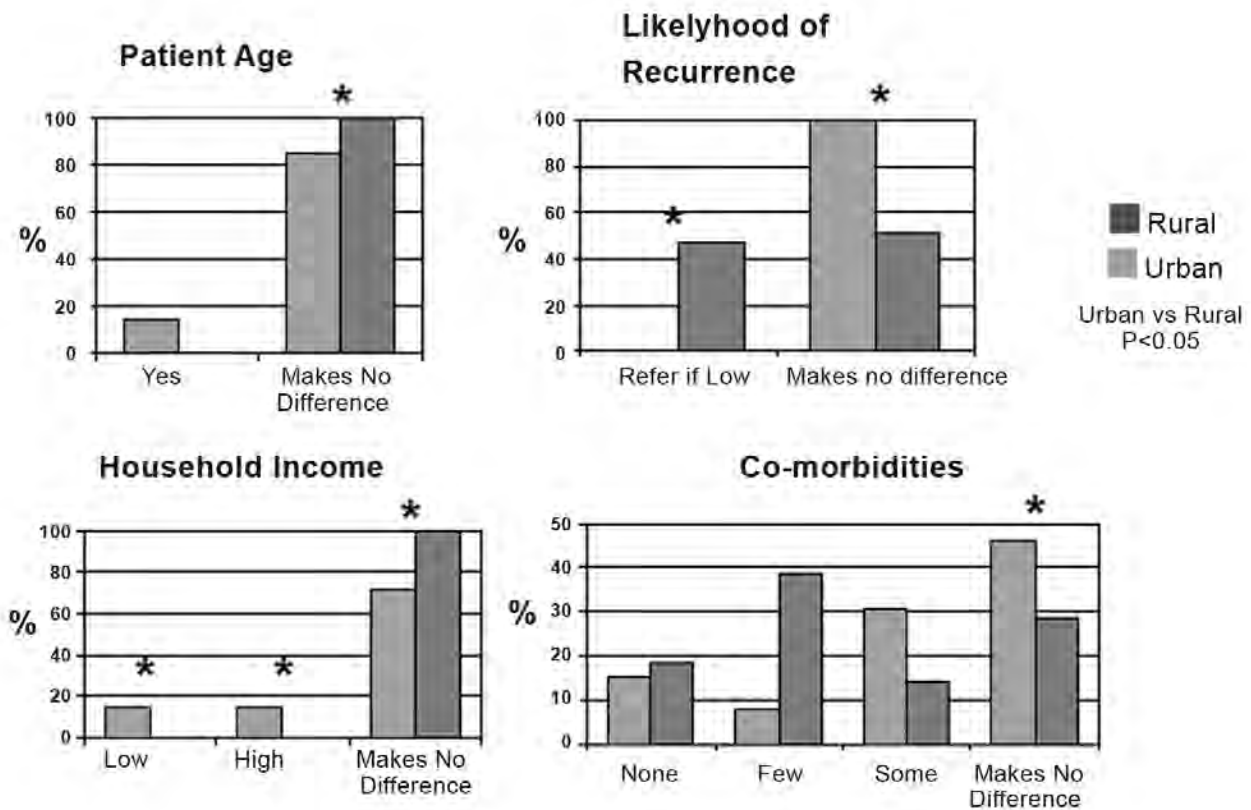


Figure 2. Subgroup analysis of urban versus rural surgeons is summarized. Rural surgeons were more likely to consider the likelihood of cancer recurrence and urban surgeons were more likely to consider household income when determining which patients to refer. (* denotes statistical significance of $P < 0.05$ between urban and rural surgeons for that category)

varies regionally. This variation likely has some effect on referral patterns.

We were surprised that 29% of the general surgeons thought that breast reconstruction masks a local recurrence even though there is evidence to the contrary.¹⁵⁻¹⁷ This number is less than the 47% of general surgeons who thought local recurrences were masked by reconstruction in Takahashi et al’s study.² Additionally, 44% of our respondents stated they would only refer patients to a plastic surgeon if the “chance” of a local recurrence was low. Most local recurrences in breast reconstruction patients occur superficially and systemic recurrences are not masked by the reconstruction.¹⁸ Almost half (47%) of the rural surgeons only refer patients if local recurrence chance is low, compared to 0% of urban surgeons who considered this factor. This may be the result of the urban surgeon group representing surgeons at multi-specialty comprehensive breast centers who may practice evidence-based medicine more consistently.

Some general surgeons could be influencing a patient’s decision significantly if they believe there is a chance of a local recurrence. Takahashi et al found that general surgeons in Japan needed to be better informed

about breast reconstruction and understand how their own values and biases may effect which of their patients receive breast reconstruction information.² In this study, a significant number of general surgeons only provide breast reconstruction information to patients who are young (37%), if the “chance” of local recurrence is low (44%), or if the patient is concerned about their sexual image (35%).

Patients 55-64 years old get breast reconstruction about half as often as patients 45-54 years old even though breast reconstruction is safe and effective in older patients.¹⁹⁻²⁰ The older patients may have more comorbidities, but cultural biases may also affect this rate. This cultural bias likely also affects the referring general surgeons who are more likely to offer reconstruction to younger patients, as physical appearance may be perceived as less important in older patients. As the United States population ages, these cultural assumptions about breast reconstruction and age may need to change.

In examining surgeons based on length of practice, the only difference found was that younger surgeons

agreed more often with the statement, "I am reluctant to damage healthy tissue for a breast reconstruction." Admittedly, this was a small number of surgeons, since only 5% of the overall survey population strongly agreed or agreed with the statement, but these were all surgeons who had been in practice <15 years. The reason for this is unclear. It may be that referring breast surgeons' views about use of autologous breast reconstruction may change as they get older. It could also mean that younger general surgeons favor tissue expansion with implants over autologous breast reconstruction. There has been a trend for younger, more active patients to favor tissue expansion with implants in recent years due to donor site morbidity concerns. This is also supported by data showing that TRAM flaps have higher rates of abdominal wall weakness and hernias.²¹⁻²³

Several comments were received with the survey responses. Some had to do with the type of reconstructions available such as, "I have very few patients who would benefit from a TRAM," and others demonstrated biases, such as, "Most women having mastectomy are either elderly or have bad disease." Others gave insightful comments such as, "...patients who go into reconstruction fully informed of the results have excellent outcomes."

Limitations to our study include problems that occur with any survey research. There is an inherent selection bias, and our results could be skewed by a high number of nonresponders. We had a 36% response rate from a statewide general surgeon population. Our high nonresponse rate is probably at least in part due to the fact that many of these surgeons do not practice breast surgery and therefore did not respond to the mailed survey. We had a response rate of 84% male and 16% female, which is similar to the population makeup of general surgeons in Wisconsin (89% male, 11% female, data from Wisconsin Medical Society). The data is also susceptible to recall bias since we are asking questions about volume of breast surgery performed and practice habits and values. Our response rate was only 36%, and we did only include breast surgeons in Wisconsin. Wisconsin has a heterogeneous population of urban and rural surgeons. As Takahashi et al pointed out in their study, a low response rate might reflect an underestimation of the passive attitudes that are held about breast reconstruction.² We did not study how practice barriers and practice management issues might effect breast reconstruction utilization. The above factors may influence referral patterns.

CONCLUSIONS

Breast reconstruction rates remain low despite proven safety and patient satisfaction. General surgeons in the current study report that patient refusal accounts for a large proportion of the eligible patients who go without reconstruction. Referring general surgeons have biases that affect the discussions they have with patients about reconstruction. There are also likely patient biases that affect reconstruction utilization that need to be further studied. Additionally, plastic surgeons need to educate our colleagues and be more available for breast reconstruction procedures.

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Fulminant Myopericarditis from Phenytoin-Induced Systemic Lupus Erythematosus

Brett D. Atwater, MD; Zhaowei Ai, MD, PhD; Matthew R. Wolff, MD

ABSTRACT

Myocarditis and pericarditis are identified at autopsy in up to 50% of patients with systemic lupus erythematosus. However, clinical symptoms of heart failure are unusual, occurring in only 5%-7% of patients. Drug-induced lupus is rare and typically causes classic lupus symptoms of rash, fever, pleuritis, renal insufficiency, and arthritis. We present an unusual case of drug-induced lupus from chronic phenytoin use in a man who presented with symptoms of fulminant myopericarditis. To our knowledge, this is the first such case reported in English.

INTRODUCTION

Systemic lupus erythematosus (SLE) is a connective tissue disease characterized by the presence of autoantibodies and immune complexes. Cardiac involvement occurs in up to 50% of cases.¹⁻² SLE can affect any cardiac structure, including the pericardium (12%-48% of cases),³ valves (13%-65% of cases),⁴⁻⁵ coronary arteries (25%-45% of cases),⁶ conduction system (incidence unknown), and myocardium (10%-40% of cases).^{3,7} Drug-induced lupus (DIL) is a well known, albeit rare complication of certain medications including procainamide, hydralazine, quinidine, diltiazam, and phenytoin, and is characterized by the abrupt onset of typical clinical manifestations including arthritis, rash, renal insufficiency, and pleuritis. We present the first reported case of DIL manifesting as fulminant myopericarditis following chronic phenytoin use.

CASE REPORT

A 57-year-old man with a history of type 2 diabetes mellitus and an isolated episode of generalized tonic-clonic seizure presented to his local emergency department with complaints of worsening pleuritic chest pain for 3 days with radiation to the left neck and ear accompanied by fatigue and dyspnea on exertion. He had been treated with phenytoin 300 mg twice daily, glyburide 10 mg twice daily, and metformin 1000 mg twice daily for the previous 7 years. Physical examination revealed elevated jugular venous pulse, tachycardia, an irregular heart rhythm, crackles in the lung bases, and 2+ lower extremity edema. Electrocardiography confirmed atrial fibrillation with a ventricular rate of 150-180 beats per minute. Transesophageal echocardiography demonstrated normal left ventricular function, an ejection fraction of 60%, and a small pericardial effusion. The patient was successfully electrically cardioverted to normal sinus rhythm. He continued to have pleuritic chest pain after cardioversion and was diagnosed with pericarditis. Naproxen 500 mg twice daily was initiated and he was referred to a cardiologist a week later for further evaluation.

On consultation, the patient complained of continuing positional chest pain with worsening dyspnea and palpitations. Physical examination was notable for a temperature of 37.8°C, jugular venous distention, bilateral lung crackles, a tachycardic irregular heart rhythm with an audible 2 component friction rub, a small left knee effusion, and lower extremity edema. Electrocardiography demonstrated atrial fibrillation, chest X-ray revealed a severely enlarged cardiac shadow and bilateral pulmonary edema, and laboratory testing was performed (Table 1). Transthoracic echocardiography demonstrated moderate dilation of all cardiac chambers (Figure 1), a left ventricular ejection fraction of 35% with global hypokinesis, diastolic dysfunction, elevated central venous pressure, and a large pericardial effusion with fibrin stranding. Cardiac magnetic

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Table 1. Pertinent Laboratory Findings at Presentation

Test	Patient Value	Normal Range
Hemoglobin (g/dL)	10.2	13.6-17.2
Hematocrit (mL/dL)	31	40-52
Platelet (K/uL)	540	160-370
WBC (K/uL)	7.5	3.8-10.5
Differential	77% N, 13% M, 9% L, 1% E, 1% B	
INR	1.7	0.9-1.1
APTT (seconds)	40.8	25-35
Thrombin time (seconds)	24.5	15-20
Cardiac Markers	Negative	Negative
TSH (uIU/mL)	2.35	0.34-5.6 uIU/mL
BNP (pg/mL)	190	0-99
ESR (mm/Hr)	106	0-5
CRP (mg/dL)	34	0-1
ANA	1:2560	Negative
Anti-DS DNA (IU/mL)	2	0-30
SSA (Ro) (U)	2.1	0.0-24.9
SSB (La) (U)	1.8	0.0-24.9 U
Anti-Histone antibody	3	(<1 negative, 1-1.5 borderline, >1.5 positive)
Anti-Cardiolipin antibody	Positive	Negative
Lupus Anticoagulant	Positive	Negative
Direct Coombs	Negative	Negative
UA	0-2 RBC	0-2
Phenytoin (mcg/mL)	9.4	10.0-20.0

ANA=anti-neutrophilic antibody; Anti-DS DNA=anti double-stranded DNA antibody; APTT=activated partial thromboplastin time; BNP=brain natriuretic peptide; CRP=C-reactive protein; ESR=erythrocyte sedimentation rate; INR=international ratio; TSH=thyroid stimulating hormone; UA=urinalysis; WBC=white blood cell count.

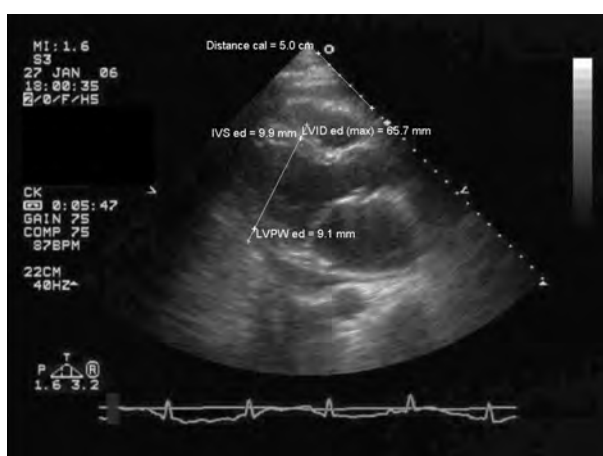


Figure 1. Two-dimensional transthoracic echocardiogram in parasternal long axis view obtained at the time of diagnosis demonstrating an enlarged left ventricle with end diastolic diameter of 65.7 mm (normal <55 mm). IVS=intraventricular septum; LVID=left ventricular internal diameter; LVPW=left ventricular posterior wall; ed=end-diastolic.

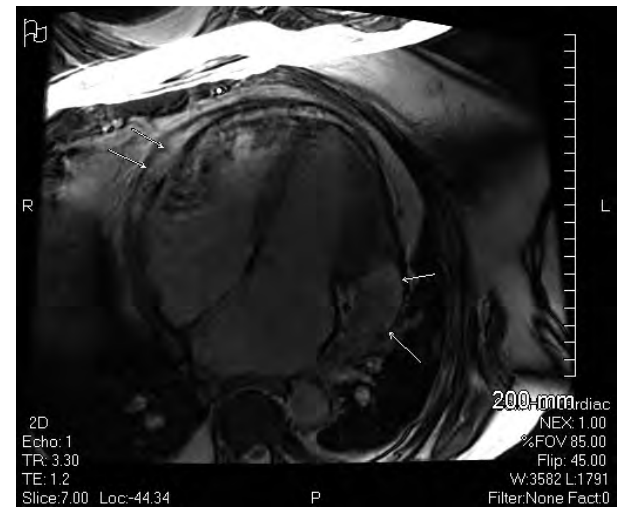


Figure 2. Contrast-enhanced cardiac magnetic resonance image in 4-chamber view demonstrating dilated cardiac chambers and a large, fibrinous pericardial effusion (arrows).

resonance imaging demonstrated global left ventricular hypokinesis with an ejection fraction of 43%, a thickened pericardium with adherence of the visceral and parietal pericardium (Figure 2) but normal left ventricular rest perfusion and no delayed myocardial enhancement to suggest scarring.

The patient was diagnosed with DIL, and phenytoin was discontinued. Methylprednisolone 80 mg daily, colchicine 0.6 mg daily, metoprolol succinate 50 mg daily, furosemide 20 mg twice daily, and lisinopril 5 mg daily were started for left ventricular dysfunction, and warfarin 5 mg daily and amiodarone 400 mg twice daily for treatment of atrial fibrillation. The patient's chest pain and dyspnea improved quickly. The methylprednisolone was transitioned to prednisone 20 mg twice daily and he was discharged home on the remainder of his medical regimen in good condition. An echocardiogram performed a month after discharge demonstrated normal sized cardiac chambers, resolution of the pericardial effusion, and ejection fraction of 65% (Figure 3). The prednisone and colchicine were discontinued, and the patient has had no further episodes of chest pain or dyspnea.

DISCUSSION

Unlike SLE, DIL usually occurs in middle age and both males and females are affected equally. African American patients are seldom affected. Both DIL and SLE are associated with elevated anti-neutrophilic antibody, erythrocyte sedimentation rate, and C-reactive protein. SLE is associated with positive anti-double

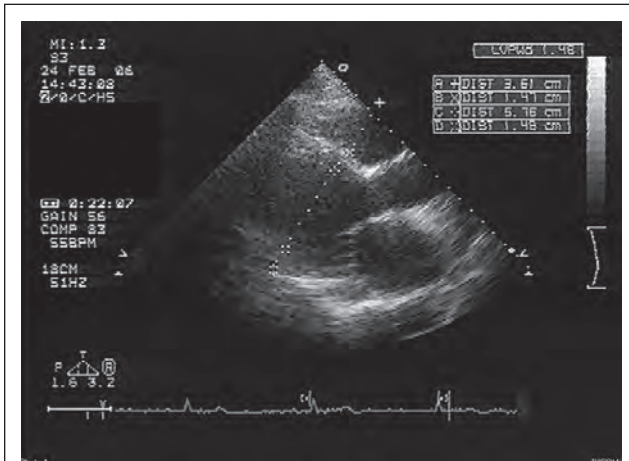


Figure 3. Two-dimensional transthoracic echocardiogram in parasternal long axis view obtained 1 month after discontinuation of phenytoin demonstrating near-normal left ventricular size (end diastolic diameter of 57.6 mm).

stranded DNA antibodies and low serum complement whereas DIL is associated with positive anti-histone antibodies with negative anti-double stranded DNA antibodies and normal complement.

DIL was first reported in association with hydantoin class anti-epileptic agents in 1957.⁸ Since then, isolated cases have been reported with symptoms including fever, arthritis, butterfly rash, lymphadenopathy, and renal dysfunction. One German report of mesantoin DIL with symptoms of recurrent seizure, pleuritis, and myopericarditis demonstrated improvement with withdrawal of the drug and treatment with prednisone and chloroquine.⁹ We obtained complete symptomatic resolution and return of normal left ventricular size and function by discontinuing the phenytoin, and treatment

with moderate dose prednisone and colchicines.¹⁰ This rare case of myopericarditis resulting from DIL stresses the importance of recognizing adverse drug reactions early in a patient's course and treating appropriately.

Funding/Support: None declared.

Financial Disclosures: None declared.

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New reporting requirements for nonprofit organizations

Robert J. Foulks, Jr. CPA, CAE
Chief Financial Officer, Wisconsin Medical Society

Tax-exempt organizations, including county medical societies and not-for-profit hospitals, will be facing many changes when they file tax returns for 2008 due to a redesigned Form 990. Last month, the Internal Revenue Service (IRS) released revised instructions to Form 990, the informational tax return required for tax-exempt organizations. The form was redesigned following draft releases and comment periods that began more than a year ago. Previous to this redesign, Form 990 had not been rewritten since 1979. A final revision of the instructions for the new Form 990 will be released later this year, but the IRS has indicated there will not be significant changes at this point.

The new Form 990 consists of an 11-page core form and 16 schedules to be completed by the organizations that meet the applicable requirements for the schedules. According to the IRS Web site, the changes to the form are intended to enhance transparency, promote tax compliance, and minimize the burden on the organization filing the form. The previous Form 990 failed to adequately report changes in the law for the increasing size, diversity, and complexity of the tax-exempt organization. There are now more than 1.4 million charities, and individual and corporate donations topped \$250 billion in 2006.

Some of the major changes in the new form that are of interest to the medical community deal with areas of governance, enhanced reporting of compensation, and policies regarding relationships with insiders and other related organizations, and as such physicians serving as CMS officers or as directors for other non-profit organizations should familiarize themselves with the new requirements. *Part VI—Governance, Management, and Disclosure* requests information about policies not required by the Internal Revenue Code. And while reporting has changed, it should be noted that there has been no significant change in the tax law covering 501(c)(3)-charitable organizations or 501(c)(6)-trade and professional organizations.

Tax-exempt organizations should review the new form and instructions prior to year-end to assess whether current policies and procedures are adequate to demonstrate good governance and transparency. Each organization should have the following policies or procedures in place:

- Written conflict of interest policy
- Annual disclosure of interests
- Whistleblower protection policy
- Document retention and destruction policy
- Process for determining compensation for officers, directors, trustees, or key employees
- Written policies and proce-

dures governing the activities of chapters, branches, and affiliates to ensure consistency with the activities of the organization

- Documentation of meetings and actions of its governing bodies and committees
- Policy for review of the Form 990 prior to filing

The new form includes a schedule (Schedule O) that requires explanations and narratives for specified questions in the core form and related schedules. It also allows organizations to supplement information reported on the Form 990, even if there is not a specific instruction requiring the organization to do so.

An additional new schedule of interest to the medical community is Schedule H, Hospitals. This must be completed by organizations that operate 1 or more facilities that are recognized as a hospital according to state law. The previous Form 990 did not provide for the reporting of community benefits activities or demonstrate how nonprofit hospitals serve the public in a manner that justifies their tax exempt status. The form is entirely new and very extensive, which will increase the reporting burden for those required to file the schedule. The IRS has granted some transition relief in delaying the effective date for some of the parts to allow organizations time to modify reporting systems to meet the new reporting requirements.

Schedule H consists of 6 parts:

- **Part I, Charity Care and Certain Other Community Benefits at Cost.** Seven separate categories of community benefit are reportable. This is optional for 2008.
- **Part II, Community Building Activities.** Reports the cost of community building activities. This is optional for 2008.
- **Part III, Bad Debt, Medicare, and Collection Practices.** Requires reporting of bad debt and requests information regarding the organization's debt collection practices. This is optional for 2008.
- **Part IV, Management Companies and Joint Ventures.** Requires information regarding management companies and joint ventures in which the organization's officers, directors,

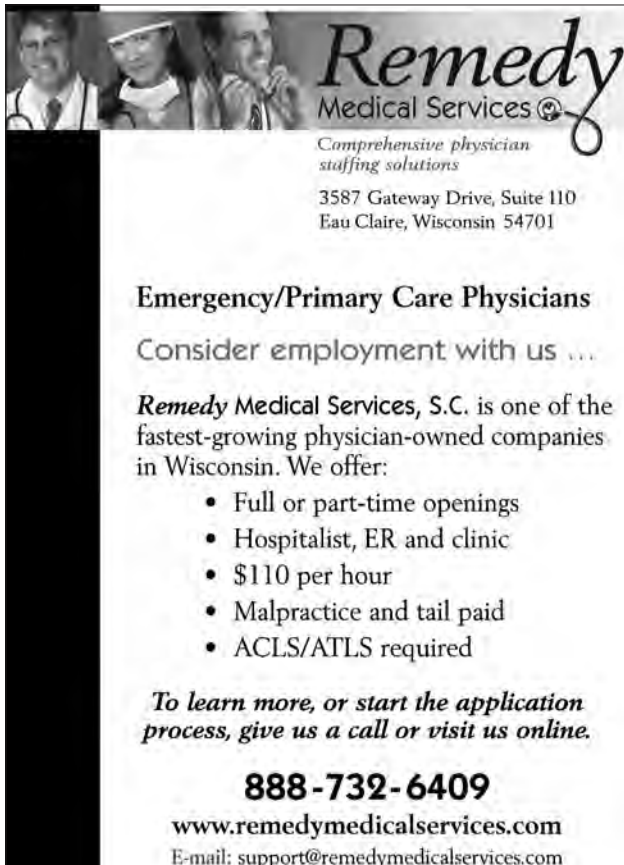
trustees, key employees, medical staff, or employed physicians who have an aggregate ownership percentage exceeding 10% of the entity. This is optional for 2008.

- **Part V, Facility Information.** Requires a list of each facility that is licensed, registered, or similarly registered as a health care facility. This is required for 2008.
- **Part VI, Supplemental Information.** Provides information demonstrating how the entity is serving its communities, including needs assessments, education of patients about eligibility for charity care, and government assistance programs. This part also asks for information on relationships with others in an affiliated system and information to supplement responses in

other parts of Schedule H. This is optional for 2008.

There are other new schedules with various triggers or thresholds to determine if they are applicable. Part IV of the new Form 990, "Checklist of Required Schedule," will help an organization determine the schedules it must complete to avoid incomplete filings and potential penalties.

Each organization should review its bylaws and policies to assure that they are in a position to fully complete the form and required schedules. There is still time in the current year to take action to make the necessary changes. Board members and staff should consult with the organization's tax preparer or advisor to determine their level of preparedness. The forms and instruction are available from the IRS at www.irs.gov.



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Jonathan I. Ravdin, MD

Talent, teamwork give rise to best kidney transplant outcomes in Midwest

Jonathan I. Ravdin, MD

Dean and Executive Vice President, Medical College of Wisconsin

When compassionate care convenes with substantial clinical experience, scientific innovation, and progressive leadership, you achieve the level of success garnered by the Froedtert & The Medical College of Wisconsin's (College) kidney transplant program. The program was identified in 2008 as having the best outcomes in the Midwest by the Scientific Registry of Transplant Recipients (SRTR).

Of the 15 largest renal transplant centers in the 10-state Midwest region, Froedtert & The Medical College of Wisconsin ranks number 1 in both patient and graft survival, according to SRTR, whose reports are published by the US Department of Health and Human Services. The 1-year survival rate for patients receiving a kidney transplant here is 99.2%—about 3% higher than the national average. In addition, the 1-year kidney graft survival rate is 96.4%, compared with a national average of only 92.4%.

Since our first kidney transplant in 1967, College faculty have performed thousands of the procedures, most recently under the direction of Christopher P. Johnson, MD, professor and chief of transplant surgery. Doctor Johnson has been with the College for 20 years, and many nurses, staffers, and surgeons in the pro-

gram have a comparable service record. The combination of individual and institutional experience is a contributing factor to our impressive outcomes.

We also benefit from performing between 120 and 140 renal transplants annually, which is sufficient volume to perpetuate our expertise, develop newer immunosuppressive methods and techniques, and incorporate those into practice. This is not always possible in a smaller program.

The muscle behind our kidney transplant program is the abundant talent from multiple disciplines coalesced within an academic medical center. The Froedtert & The Medical College of Wisconsin program draws on our expertise in cardiology, since cardiovascular issues abound in the population of patients with renal failure. Interventional radiologists are major contributors due to their skill managing the many complications kidney transplant patients can have. Pre-operative and post-operative support spans many College departments, all important to our efforts.

Most imperative is the synergistic relationship between the College's Division of Transplant Surgery, which houses the transplant program in the Department of Surgery, and the Division of Nephrology, which oversees the management of patients with kidney disease within the Department of Medicine. The

teams work together exceedingly well to make good medical decisions both before and after transplant. Sundaram Hariharan, MD, professor and chief of nephrology, has emphasized cooperation since his recruitment to the College 12 years ago. He is a nationally recognized leader in transplant medicine.

Doctor Hariharan and his medical team have initiated a number of measures to improve transplant patient management. For example, his team instituted pre-transplant cardiac screening and developed guidelines for good blood pressure, cholesterol, and diabetes control for patients after transplant. He set strict health standards for living donors, and he expanded the clinical workforce.

Doctor Hariharan also spearheaded a significant translational research effort. In 1996, the College experienced its first case of polyoma BK virus infection in a transplant recipient. This virus causes infection in the transplanted kidney that mimics organ transplant acute rejection when examined by renal biopsy. The therapeutic approach for acute rejection and polyoma BK virus infection are entirely different with acute rejection requiring increased immunosuppression, which can worsen polyoma BK virus infection. Hence, it is critical to differentiate acute rejection and polyoma BK virus infection to optimize kidney transplant graft survival.

The virus was newly recognized in the late 1990s, and there were no tools to support best practices. Doctor Hariharan engaged basic scientists at the College to design a polymerase chain reaction (PCR) assay to test for the virus. The novel test was successfully developed by a multidisciplinary College team and became available for clinical use in September 2001. Utilization of polyoma BK virus PCR has helped clinicians to identify this infection accurately in renal transplant recipients.

In 2005, the transplant program began an aggressive screening protocol, testing all patients at intervals of 1, 3, 6, 12, and 24 months for polyoma BK virus in the blood for early identification prior to the occurrence of transplant kidney damage. Patients with significant polyoma BK virus infection have been subject to reduction in immunosuppression with close monitoring. With the above protocols, the transplant team has prevented and picked up early infection, and this has played an important role in improving kidney transplant survival. The College renal transplant team has effectively prevented graft failure secondary to polyoma BK virus infection. Such innovation—the development of an on-site test

using sophisticated molecular techniques to address a specific clinical problem—is only possible at an academic medical center, where clinicians and basic scientists can unite to improve patient care.

Promising research continues at the College. For example, both basic science and clinical faculty in transplant surgery are examining the causes of oxidative stress in organs. Oxidative stress occurs when an organ is removed from the body for transplantation and thereby deprived of oxygen for an extended period of time. Ensuing damage becomes evident upon the reperfusion of the organ with oxygenated blood. College researchers are working to identify mechanisms to minimize oxidative stress and thus keep donor organs healthier for transplantation.

Additionally, many faculty members from transplant surgery and nephrology are members of the College's Kidney Disease Center. Directed by Richard J. Roman, PhD, professor of Physiology, the Kidney Disease Center provides infrastructure for scientists and clinicians to work on various facets of kidney disease research. Adult and pediatric nephrologists, transplant surgeons, physiologists, and endocrinologists are working together

under Dr Roman's supervision and have successfully obtained extramural grant support to advance research on kidney disease.

Furthermore, patients transplanted at Froedtert Hospital have access to many national and international multicenter clinical trials on newer, innovative immunosuppressive agents that can further enhance kidney transplant outcomes. Some of these clinical trials are based on scientific study performed by clinical investigators of the College.

The College also serves the greater transplant community through its close affiliation with the Wisconsin Donor Network, the organ procurement organization for eastern Wisconsin. The College historically provides medical directorship for the Network, a role currently held by Dr Johnson. He assumes responsibility for donor management, organ evaluation, and many other procurement questions and challenges faced by the organization.

This is another instance of the College's focus on teamwork, the foundation upon which our transplant program is predicated, and a key reason why we expect to continue our leadership in this field and best serve the patients in our region.

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Another round of Stark law changes coming your way as early as October 1, 2008

Alyce C. Katayama, JD; Sarah E. Coyne, JD; Kerry L. Moskol, JD

Sweeping changes to the Stark regulations will force many arrangements between physicians and hospitals, particularly hospital/physician joint ventures, to undergo significant restructuring.

On August 19, 2008, the Centers for Medicare & Medicaid Services (CMS) finalized several significant changes to the Stark rules, as part of the 2009 final hospital inpatient prospective payment system rule (IPPS Rule).¹ The Stark rules implement the Stark law, which prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which the physician has a financial relationship unless a Stark law exception applies.² Similarly, the entity to which the DHS is referred in that circumstance may not bill for the DHS.

The Stark rule changes made in the final IPPS Rule will have a major impact on relationships between physicians and hospitals. Some of this impact will occur as early as October 1, 2008, and the rest will take effect on October 1, 2009. This article highlights some aspects of the changes. These changes will be the focus of a Wisconsin Medical Society educational program to be offered in October. Some of the

changes provide more flexibility than the rules proposed last year;³ other changes are more restrictive.

Percentage-Based Compensation Formulae

Percentage-based compensation arrangements for *space and equipment rental* charges will be a thing of the past, as of October 1, 2009. In the final IPPS rule, CMS amended the exceptions for rental of office space, rental of equipment, fair market value, and indirect compensation arrangements to prohibit the use of compensation formulae based on a percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the leased office space or leased equipment. CMS initially proposed a much broader prohibition under which percentage-based compensation formulae would only be permitted for personally performed physician services. However, in the final rule, CMS took a more targeted approach to address its concerns with percentage-based compensation in the context of lease arrangements.

Unit-of-Service ("Per-Click") Payments in Lease Arrangements

The final IPPS rule significantly limits the use of "per-click" payments in the context of lease arrangements. Specifically in the final rule, effective October 1,

2009, CMS revised the space and equipment lease exceptions, the fair market value exception, and the exception for indirect compensation arrangements to prohibit per-click payments to a physician lessor, where the payments reflect services provided to patients referred by the physician to the lessee. CMS further stated that the per-click prohibition applies regardless of whether the physician is the lessor or whether the lessor is an entity in which the referring physician has an ownership or investment interest. Moreover, CMS stated that the prohibition could also apply in situations where the lessor is a DHS entity that refers patients to a physician lessee or a physician organization lessee.

"Stand in the Shoes" Provisions

CMS has opted to simplify the physician "stand in the shoes" analysis, effective October 1, 2008. Stand in the shoes essentially means that if physician organizations contract with an entity such as a hospital, the physicians are deemed to have made that contract as well. The upshot is a limited ability to take advantage of the indirect compensation exception to the Stark prohibition. However, under the finalized "stand in the shoes" analysis, only physicians who have an *ownership or investment interest* in a physician organization will now be deemed to stand in the shoes of the physician organization for purposes of compliance with

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Stark law. Physicians with other compensation links to their organizations (such as employment) will not stand in the organization's shoes. CMS also made 2 important clarifications regarding the stand in the shoes analysis:

1. Physicians who have only titular ownership are not required to stand in the shoes of their physician organizations. CMS considers an ownership or investment interest to be titular where the physician is not able to claim or is not entitled to any of the financial benefits of ownership or investment, including but not limited to the distribution of profits, dividends, proceeds of sale, or similar returns on investment.
2. The stand in the shoes requirement does not apply to an arrangement that satisfies the requirements of the Academic Medical Center exception to the rules.

Services Provided "Under Arrangements"

Starting October 1, 2009, entities (including physicians) that provide services to hospitals "under arrangements" (ie, the hospital bills for the services but has an arrangement for the other entity to provide the services) will now be considered DHS entities *themselves* for Stark law purposes. Prior to the final IPPS rule, only the person or entity that billed for DHS was considered to be "furnishing" the DHS. However, in the final IPPS rule, CMS amended the definition of "entity" to clarify that a person or entity is considered to be furnishing DHS if it is the person or entity that has (1) performed the DHS (even if another entity bills for the services as DHS) or (2) presented a claim for Medicare benefits of the DHS. As a result of this change, physicians will be limited in their ability to refer patients to "under

arrangement" service providers in which they have an ownership or investment interest.

Amendments to Agreements — Set in Advance

Under the Stark law, CMS requires compensation in a hospital-physician arrangement to be "set in advance," in writing, in a manner that will not vary over the course of the agreement. Under the new rule, CMS takes the position that amendments to the compensation provision of an agreement will be consistent with the set in advance requirement as long as:

1. All of the requirements of an applicable exception are satisfied.
2. The amended rental charges or other compensation is determined before the amendment is implemented and the formula is sufficiently detailed so that it can be verified objectively.
3. The formula for the amended rental charges does not take into account the volume or value of referrals or business generated by the referring physician.
4. The amended rental charges or compensation remains in place for at least 1 year from the date of the amendment.

CMS further clarified that this interpretation applies to all of the Stark law exceptions for compen-

sation arrangements that include a 1-year term requirement for satisfying the exception.

Conclusion

These topics and other aspects of the Stark rules will be covered in more depth in the Society's October educational programs, which are being held October 14 in Wausau, October 15 in Green Bay, October 21 in Waukesha, and October 22 in Madison. The authors will also provide a Stark Law Primer and an update on the anti-markup rule. More information about the programs can be found at www.wisconsinmedicalsociety.org/education.

End Notes

1. IPPS rule. Available at: <http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf>. Accessed August 28, 2008.
2. Under the Stark Law, DHS entities are those providing any of the following "designated health services": clinical laboratory services, occupational and physical therapy services, radiology services, DME and supplies, prosthetics, orthotics and prosthetics devices and supplies, outpatient prescription drugs, radiation therapy services and supplies, parenteral and enteral nutrients equipment and supplies, home health services, and inpatient hospital services.
3. Lyons L, Katayama A. Per-click, under arrangement, mark-up, and other dirty words. *WMJ*. 106:5;280-284.

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E.G. Schramka, JD,
CPA, PFS, CVA

Seven reasons to consider a trust

E.G. Schramka, JD, CPA, PFS, CVA

Depending on your estate planning objectives and the individual characteristics of your intended beneficiaries, you may want to consider forming a trust. A trust is a contractual relationship between an individual, a trustee and a beneficiary for the trustee to hold legal title to property, formerly owned by the individual, for the benefit of the beneficiary.

The two basic kinds of trusts are *inter vivos* trusts, those created by an individual during his life, and testamentary trusts, those that come into being after an individual's death. There are many reasons to set up a trust. For example, the use of a trust can help to:

- **Avoid probate.** A revocable trust substitutes for a will. If, during an individual's lifetime, assets are titled in the name of the revocable trust, upon the individual's death the assets will not have to go through probate. The probate process can be costly and time-consuming, and all your assets will be a matter of public record. Since Wisconsin is a marital property state, a married couple can set up a joint revocable trust to hold all their marital property.
- **Reduce estate taxes.** Remove life insurance proceeds from your estate with an irrevocable

life insurance trust. When an individual dies owning a life insurance policy, the amount of the proceeds could be subject to the federal estate tax at a flat rate of 45%. If an existing policy is transferred into an irrevocable life insurance trust and the individual lives for at least 3 years from the date of the transfer, the insurance proceeds are not subject to estate tax. If the individual is applying for a new policy, the trust should apply for the policy to avoid the 3-year rule. Note there may be gift tax consequences to transferring cash into the trust so the trustee can pay the premiums.

- **Provide for a second spouse and children from your first marriage.** You can provide for the surviving spouse in a second marriage while assuring that on the death of the surviving spouse, the remaining trust assets will go to the children from the first marriage using a qualified terminable interest property trust or QTIP trust.
- **Utilize estate tax exemption.** A family trust, a credit shelter trust, or bypass trust allows you to "use up" one spouse's estate tax exemption, provide for the surviving spouse, and avoid estate taxes upon the surviving spouse's death. At death, any assets that go to the surviving spouse are not subject to estate tax. In addition, currently \$2 million of assets (scheduled to increase to \$3.5 million in 2009)

can go to non-spouses without triggering the estate tax.

- **Provide for a disabled child.** Using a special needs trust, you can provide benefits to a disabled child over and above what government assistance covers, without affecting the beneficiary's eligibility for government assistance.
- **Contribute to charities.** A charitable lead trust and charitable remainder trust are possibilities if contributing to charities is a priority.
- **Provide creditor protection.** You can protect your estate from creditors or a divorcing spouse by creating a spendthrift trust.

Flexibility, but at a cost

The income and principal distribution provisions of trusts can be very flexible. For example, the income distribution provisions can call for all the income to be distributed at least annually or for income to be distributed for beneficiaries' health, maintenance, support, and education (an ascertainable standard). A similar standard could be established for principal distributions. Principal distributions could be made when the beneficiaries reach certain ages. Or, you could give the trustee absolute discretion as to when to make principal or income distributions to beneficiaries.

There are, however, disadvantages to trusts, including:

- Upfront costs of drafting.
- Filing of annual income tax returns.

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- Finding a trustee and a successor trustee. Trustees have a fiduciary obligation to administer the trust assets in accordance with the terms of the trust and applicable law, so you will need to name a trustee and successor trustee who understand their responsibilities. Depending on the type of assets in the trust and their value, it may make sense to incur the fees to have a corporate trustee administer the trust.
- The inability to change the trust once it becomes irrevocable.

Conclusion

Trusts can be a very flexible vehicle in meeting your objectives and your and your survivor's income needs. However, you need to balance the flexibility that you have when drafting the income and principal distribution provisions with the additional administrative costs that trusts may require.

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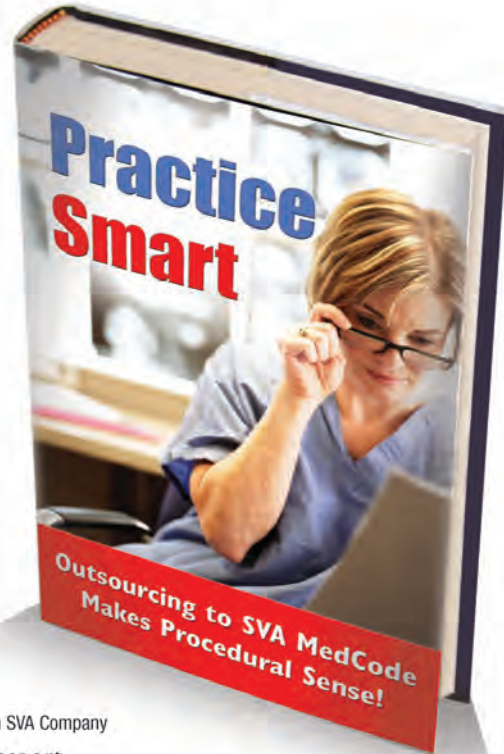
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