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Chapter 1 : Summary of the Medical Treatment Planning and Decisions Act (2nd edition) - calendrierdelasc

A Text-Book of the Medical Treatment of Diseases and Symptoms by Nestor Tirard Marihuana and Health A Report to the Congress From the Secretary, Department of Health, Education, and Welfare; January 31, by Dept; Of Health, Education, and Welfare.

This article has been cited by other articles in PMC. Short abstract Using a formal treatment plan template enables clearer and more fruitful discussions between physician and patient and among physicians within a practice. Treatment plans are vital to formal chemotherapy teaching sessions for patients beginning therapy, regardless of disease histology or treatment intent. The concept of a written treatment plan template and summary provided to the patient and referring physicians came as a complete surprise to the physicians in my practice. Treatment plans and summaries were originally piloted in our office as part of a voluntary effort with ASCO. The usual reluctance to take on any additional paperwork was voiced by everyone involved. However, it quickly became obvious that the use of a formal treatment plan template had broad benefits. Discussions with patients became more fruitful, and decisionsâ€”not only those between the physician and the patient but also those among the physicians within the practiceâ€”became clearer. Treatment plans were rapidly adopted for routine use as part of a formal chemotherapy teaching session for patients beginning therapy, regardless of disease histology or treatment intent. Before the use of a written treatment plan, a patient who was seen for a new diagnosis of cancer would meet with the physician to discuss the natural history of the disease and develop a plan outlining potential options for therapy and follow-up. The patient might be given written information, usually in the form of drug information sheets or pamphlets about the disease itself. He or she might meet with one of the chemotherapy nurses to discuss issues regarding venous access and to review in broad terms the adverse effects of treatment discussed in the initial visit with the oncologist. The patient would then return for chemotherapy treatment, at which point issues regarding the acute adverse effects of chemotherapy would be discussed again by the oncology certified nurse administering treatment. With the advent of treatment planning, issues regarding the natural history of the disease continue to be discussed in the first visit with the physician, but far more focused issues surrounding the stage of the disease and the goals of therapy have become the bulk of the initial discussion. In the second visit, a treatment plan is given to the patient as part of a formal chemotherapy teaching session. This session may be led in our office by either a physician or a nurse practitioner. Patients have often stated that they absorbed only part of what was discussed during the first visit with the physician. In the second visit, the patient is in a better place to ask questions regarding the natural history of the disease, the risk of recurrence, and the intent of the treatment, as well as to formally review the acute adverse effects of chemotherapy and discuss the late and long-term effects of chemotherapy. A follow-up plan is discussed in the context of treatment. This may include survivorship planning, restaging intervals for the patient with a palliative-intent treatment plan, or scans and interventions for the patient with a curative-intent treatment plan. The benefit of discussing long-term effects of chemotherapy in a setting separate from the initial visit became immediately obvious to all involved, as patients discussed their disease in the context of the health continuum rather than in terms of an immediate and imminently fatal event. Patients have recounted that it was helpful to see their physicians thinking of their disease in the context of their overall lives rather than as an acute traumatic event. The ability to communicate information to patients in a written form has also produced tangible benefits. Patients have often returned for subsequent visits either during their course of therapy or after completion of treatment with questions about disease stage, initial intent of therapy, and potential long-term adverse effects that they might otherwise not have brought to medical attention. For example, early discussion of the potential cognitive effects of chemotherapy now often leads to additional discussion many months after completion of treatment of issues the patient might otherwise have been reluctant to share with his or her provider. Reproductive discussions and discussions regarding sexual health were often avoided by both patient and physician in the long-term follow-up of patients who had received adjuvant chemotherapy. However, with written treatment plans and summaries detailing late and long-term effects, patients now understand that these are areas open for

discussion and spontaneously begin discussions about these effects far more frequently. Appropriate referrals can be made early in the course of survivorship to address these issues. Similarly, recording in a written form the intent of therapy, whether curative or palliative, often prompts patients to initiate discussions later in the treatment course. Particularly in the event of palliative therapy, end-of-life wishes and planning are addressed at the same time as benefits and limits of chosen treatments. Rather than being addressed in one complex and difficult visit, end-of-life and do-not-resuscitate issues are now topics in a more fluid and ongoing discussion. Physicians and nonphysician practitioners in our practice have reported less stress surrounding such discussions because they now occur in the context of care rather than as defined events. The ability to communicate all of this information to the primary care physician in a comprehensive and meaningful way has been uniformly welcomed. At the chemotherapy teaching visit, when the written treatment plan is provided to the patient, a calendar is also created, and copies of all of these documents are routinely provided to the primary care physician as well as to the surgeons, radiation oncologists, and other physicians who are key figures in the health care of the patient. By engaging all of the physicians in the plan, we can make sure they know at which points in the cycle of therapy patients may present to them. We have had experiences including a primary care physician contacting our office stating that a patient had called with upper respiratory tract symptoms; this would otherwise have been treated as a community acquired viral infection, but having received the treatment plan and calendar, the physician was aware of the neutropenic effects of chemotherapy. Although we have not studied this in a systematic way, it has been our experience that adverse effects in patients are minimized with the use of treatment plans, and we hope that hospitalization and emergency room visits are diminished. Primary care physicians have reported the ability to better assist in end-of-life discussions with their patients, with the knowledge that the patients have received written plans including intent of therapy. Although the administrative burden of preparing adequate treatment plans and summarizing treatment therapy has not been met with open arms, in our practice, the benefits have outweighed the costs. The issue of reimbursement for this added service to patients is being debated at present. One tangible benefit we have noticed is the ability to take adequate time to confirm that patients have sufficient insurance coverage not only for parenteral chemotherapy but for supportive care drugs and co-pay and deductible costs as well. In treatment planning visits, patients often disclose to the nurse practitioners issues about cost they felt were not appropriate to discuss with physicians in the context of an initial visit. This lead time has allowed us to integrate patient advocates and social services into care before patients finds themselves in financial crisis midway into treatment, as had happened in the past. In the context of a single comprehensive visit, adequate discussion of the stage of disease, natural history of disease, goal of treatment whether palliative or curative , acute adverse effects of chemotherapy, and late and long-term effects of chemotherapy and other treatments is difficult to deliver. The additional visit for treatment planning has allowed the conversation between the patient and care provider to occur in the context of the health continuum. This has both empowered our patients and produced tangible benefits for the physicians involved. The written treatment plan template has enabled communication with colleagues both inside and outside the practice, which has led to better coordination of care. Patients have reported greater satisfaction in their discussions with their care providers, not only about what is happening now but also about what to expect in the future as they transition from patients to survivors. Chemotherapy Treatment Plan and Summary Templates The ASCO chemotherapy treatment plan and summary templates were developed to help improve documentation and coordination of cancer treatment and survivorship care. They are intended to facilitate provider-to-provider and provider-to-patient communication and may be distributed to patients or providers as records of the care planned and received. It is important to note that the treatment plans and summaries are not intended to replace detailed chart documentation, such as complete patient histories and chemotherapy flow sheets. Treatment summaries are not intended to be, and should not be considered, substitutes for written or verbal communication, physical examinations and histories, or reviews of complete medical records. ASCO has developed treatment plan and summary templates for breast cancer, colon cancer, nonâ€”small-cell lung cancer, and small-cell lung cancer, as well as a generic template that can be used for any cancer diagnosis. These templates can be downloaded and customized for your practice; they are available at www.

Chapter 2 : Medical Dossier Doctor: Victim: Injuries: Synopsis of treatment: - calendrierdelascience.com

File under medical illustrations showing Summary of Medical Treatment, with emphasis on the terms related to medical calendar treatment care radiology hospitalization providers time summary. This medical image is intended for use in medical malpractice and personal injury litigation concerning Summary of Medical Treatment.

This section needs additional citations for verification. Please help improve this article by adding citations to reliable sources. Unsourced material may be challenged and removed. October For the most part, doctors and civil servants simply did their jobs. Some merely followed orders, others worked for the glory of science. Taliaferro Clark was credited with founding it. His initial goal was to follow untreated syphilis in a group of black men for 6 to 9 months, and then follow up with a treatment phase. Among his conclusions was the recommendation that, "If one wished to study the natural history of syphilis in the Negro race uninfluenced by treatment, this county Macon would be an ideal location for such a study. Eugene Heriot Dibble, Jr. From , he served as director of the Tuskegee Veterans Administration Medical Center , established in in the city by the federal government on land donated by the Institute. He and his staff took the lead in developing study procedures. Wenger and his staff played a critical role in developing early study protocols. Wenger continued to advise and assist the Tuskegee Study when it was adapted as a long-term, no-treatment observational study after funding for treatment was lost. Vonderlehr was appointed on-site director of the research program and developed the policies that shaped the long-term follow-up section of the project. His method of gaining the " consent " of the subjects for spinal taps to look for signs of neurosyphilis was by portraying this diagnostic test as a "special free treatment". Participants were not told their diagnosis. Vonderlehr retired as head of the venereal disease section in , shortly after the antibiotic penicillin had first been shown to be a cure for syphilis. Several African American health workers and educators associated with Tuskegee Institute helped the PHS to carry out its experimentation and played a critical role in the progress of the study. The extent to which they knew about the full scope of the study is not clear in all cases. Registered nurse Eunice Rivers , who had trained at Tuskegee Institute and worked at its affiliated John Andrew Hospital, was recruited at the start of the study to be the main contact with the participants in the study. Patients were told they would receive free physical examinations at Tuskegee University , free rides to and from the clinic, hot meals on examination days, and free treatment for minor ailments. Based on the available health care resources, Rivers believed that the benefits of the study to the men outweighed the risks. As the study became long term, Rivers became the chief person with continuity. Unlike the national, regional and on-site PHS administrators, doctors, and researchers, some of whom were political appointees with short tenure and others who changed jobs, Rivers continued at Tuskegee University. She was the only study staff person to work with participants for the full 40 years. By the s, Nurse Rivers had become pivotal to the study: In , Congress passed the Henderson Act, a public health law requiring testing and treatment for venereal disease. By the late s, doctors, hospitals and public health centers throughout the country routinely treated diagnosed syphilis with penicillin. However, the Tuskegee experiment continued to avoid treating the men who had the disease. In the period following World War II, the revelation of the Holocaust and related Nazi medical abuses brought about changes in international law. Western allies formulated the Nuremberg Code to protect the rights of research subjects. On July 25, , word of the Tuskegee Study was reported by Jean Heller of the Associated Press; the next day The New York Times carried it on its front page, and the story captured national attention. Peter Buxtun, a whistleblower who was a former PHS interviewer for venereal disease, had leaked information after failing to get a response to his protests about the study within the department. They were subjects, not patients; clinical material, not sick people. Vonderlehr medical doctor Eugene Dibble medical doctor Study details[edit] Subject blood draw, c. This study is known as a retrospective study , since investigators pieced together information from the histories of patients who had already contracted syphilis but remained untreated for some time. Subjects talking with study coordinator, Nurse Eunice Rivers, c. Researchers could study the natural progression of the disease as long as they did not harm their subjects. The researchers involved with the Tuskegee experiment reasoned that they were not harming the black men involved in the study because they were unlikely to get

treatment for their syphilis and further education would not diminish their inherent sex drive. Even at the beginning of the study, major medical textbooks had recommended that all syphilis be treated, as the consequences were quite severe. At that time, treatment included arsenic therapy and the "" formula. The study was characterized as "the longest non-therapeutic experiment on human beings in medical history. At that time, it was believed that the effects of syphilis depended on the race of those affected. For African Americans, physicians believed that their cardiovascular system was more affected than the central nervous system. These methods were, at best, mildly effective. The disadvantage was that these treatments were all highly toxic. The Tuskegee Institute participated in the study, as its representatives understood the intent was to benefit public health in the local poor population. The Rosenwald Fund , a major Chicago -based philanthropy devoted to black education and community development in the South , provided financial support to pay for the eventual treatment of the patients. Public Health Service summarising participants in the study Continuing effects of the Stock Market Crash of and the beginning of the Great Depression led the Rosenwald Fund to withdraw its offer of funding. Study directors issued a final report as they thought this might mean the end of the study once funding to buy medication for the treatment phase of the study was withdrawn. Medical ethics considerations were limited from the start and rapidly deteriorated. The PHS asked black Tuskegee Institute physicians to participate in the study by offering funds, employment, and interns to encourage the ongoing participation of the patients. Additionally, the study intentionally employed Eunice Rivers, a black nurse from Macon County, to be primary source of contact and build personal, trusting relationships with patients to promote their participation. The study also required all participants to undergo an autopsy after death in order to receive funeral benefits. After penicillin was discovered as a cure, researchers continued to deny such treatment to many study participants. Many patients were lied to and given placebo treatments so that researchers could observe the full, long-term progression of the fatal disease. This was prior to the discovery of penicillin as a safe and effective treatment for syphilis. The study was not secret since reports and data sets were published to the medical community throughout its duration. During World War II , of the subject men registered for the draft. These men were consequently diagnosed as having syphilis at military induction centers and ordered to obtain treatment for syphilis before they could be taken into the armed services. A PHS representative was quoted at the time saying: The US government sponsored several public health programs to form "rapid treatment centers" to eradicate the disease. When campaigns to eradicate venereal disease came to Macon County, study researchers prevented their patients from participating. Of the original men, 28 had died of syphilis, were dead of related complications, 40 of their wives had been infected, and 19 of their children were born with congenital syphilis. Original legal paper work for Sylvester Carlis related to the Tuskegee Syphilis Study is on display at the museum as well. Peter Buxtun, a PHS venereal disease investigator, the " whistleblower " Group of Tuskegee Experiment test subjects Charlie Pollard, survivor Herman Shaw, survivor The first dissent against the Tuskegee study was Irwin Schatz, a young Chicago doctor only four years out of medical school. The Center for Disease Control CDC , which by then controlled the study, reaffirmed the need to continue the study until completion; i. The cabinet-level department included the CDC. He did not succeed; it is not clear who read his work. The story broke first in the Washington Star on July 25, It became front-page news in the New York Times the following day. The panel found that the men agreed to certain terms of the experiment, such as examination and treatment. As part of the settlement of a class action lawsuit subsequently filed by the NAACP on behalf of study participants and their descendants, the U. Now studies require informed consent , [5] communication of diagnosis , and accurate reporting of test results. In , a multi-disciplinary symposium was held on the Tuskegee study: Doing Bad in the Name of Good?: Following that, interested parties formed the Tuskegee Syphilis Study Legacy Committee to develop ideas that had arisen at the symposium. It issued its final report in May What was done cannot be undone. But we can end the silence. We can stop turning our heads away. We can look at you in the eye and finally say on behalf of the American people, what the United States government did was shameful, and I am sorry To our African American citizens, I am sorry that your federal government orchestrated a study so clearly racist. The presidential apology led to progress in addressing the second goal of the Legacy Committee. The federal government contributed to establishing the National Center

for Bioethics in Research and Health Care at Tuskegee, which officially opened in to explore issues that underlie research and medical care of African Americans and other under-served people. Our estimates imply life expectancy at age 45 for black men fell by up to 1. Some of the factors that continue to limit the credibility of these few studies is how awareness differs significantly across studies. For instance, it appears that the rates of awareness differ as a function of method of assessment, study participants who reported awareness of the Tuskegee Syphilis Trials are often misinformed about the results and issues, and awareness of the study is not reliably associated with unwillingness to participate in scientific research. Sidney Olansky, Public Health Services director of the study from to If they were not, as things moved on they might have been reading newspapers and seen what was going on.

Chapter 3 : A Synopsis of Medical Treatment

While Principles of Medical Treatment is an important aid for students of medicine as well as practicing doctors the author ensures that it can be useful for the general reader too - although it must be noted that the book holds value as a historic document rather than an educational one, as the subject matter is often outdated by modern practice.

Clients may use a variety of different tools as clinical summaries. For reporting, the application reports on the percentage of all arrived appointments where the Clinical Summary Icon has been set to provided. It is important to note that clinical summaries can only be provided for patients in an ARRIVED status; therefore even once the setup below is complete, the checkbox to provide a clinical summary will be grayed out if the patient has not been arrived. Requirements for Patient Summaries The Meaningful Use rules define a Clinical Summary as an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the following: Determines whether an unfinalized note can be used as a Clinical Summary. Refers to when a v10 or v11 structured note output is used as a Clinical Summary. Set to Y if you want providers to be able to generate the Clinical Summary before the note is finalized. Set to N if you do not want providers to be able to generate the Clinical Summary before the note is finalized. Applies to v10 and v11 note. Determines which structured note section to pull free text comments, from the note associated with the same encounter, into the Clinical Summary Reason for Visit section. Determines which structured note section to pull free text comments, from the note associated with the same encounter, into the Clinical Summary Treatment Plan section. Determines which format of the Allscripts delivered Clinical Summary to generate from the daily schedule or encounter summary. If Enabled, the user can generate the clinical summary from the Daily Schedule see if it has been provided. Set this preference to N at the Enterprise level, then to Y at the User level for users who will be generating the Clinical Summary. If Enabled, the user can generate the clinical summary from the Provider Schedule see if it has been provided. Determines if the Clinical Summary can be generated from the Encounter Summary upon committing data and selecting "Save and Continue". The user can clear the check box if they do not want to provide a clinical summary for that encounter. Set to N if you want, by default, the Provide Clinical Summary check box to be unchecked. The user can select the check box to provide a clinical summary for that encounter. Set to Disable if you want the Provide Clinical Summary check box to be unchecked and disabled. Users are unable to select the check box. Pt Communication Clinical Summaries Editable: Set Y if you want the user to be able to edit this drop down seletion Set N if you do not want the user to be able to edit this drop down selection Results: Determines the number of days to pull results from the time the clinical summary is generated. Determines the number of days to pull vitals from the time the clinical summary is generated. Auto-print defaults are not required, but can be used to automate as with printing any document. If auto-print defaults are not defined, the application displays the Print dialog so you can choose the printer. The clinician receives credit for attempting to provide the Clinical Summary. If a v10 or v11 Note is linked to the encounter, that document is printed, but the CED is sent to Portal. The one exception is if the portal is Intuit Health and the Note is v10 Note. In that case the application can send the v10 Note to Portal, as well as print for the patient. If the patient does not have a preference set, the application behaves as if the preference were Print.

Chapter 4 : Full text of "A synopsis of medical treatment"

Summary of Medical Treatment Guideline Changes, January 14, Summary of Medical Treatment Guideline Changes Carpal Tunnel Syndrome, First Edition.

Approximately 3, were form letters from four groups: The remaining 86 comments were submitted by associations representing business, insurance carriers, and medical providers, as well as one law firm, a labor union, individuals, medical professionals, and businesses. All of the comments received were reviewed and assessed. The comments break down into three groups: The full Assessment of Public Comment summarized, analyzed, and responded to the comments received and it exceeds 2, words. This document is a summary of the full Assessment of Public Comment. The comments on the regulations included numerous requests to delay the effective date of the regulations and the Guidelines, clarify provisions that were not interpreted the same by all readers, clarify provisions by explicitly stating black letter law implied by the provisions, and correct typographical errors. The following changes were made to the regulations: Comments were received requesting changes to definitions, time frames, the list of pre-authorized procedures, and who resolves disputes over variances. The regulations set forth the best processes based upon the statutory authority available and, other than as described above, were not modified by the comments. In part this is due to the experience and feedback obtained through the pilot program and comments received prior to finalizing the regulations. The most significant comments received from multiple commentators are discussed below, and all of the comments received are discussed in detail in the complete Assessment of Public Comments. Some comments expressed a need for addition time before the regulations and medical treatment guidelines Guidelines took effect. In response the effective date of the regulations and Guidelines has been delayed until December 1, No changes were made to this definition. The advisory committee developing impairment guidelines developed a definition of MMI that is basically the same as the definition in this rule. The recommended definition for the impairment guidelines starts with the exact same language used in the definition in this rule and then adds additional language, but the definitions are still consistent. This provision was not changed as the Chair and Board disagree with the statutory interpretations in the comments. The purpose of this change is to speed access to care. The creation of a pre-authorized list allows for regulatory flexibility to add and remove procedures based upon best practice. The Guidelines set up best practices for treatment and will be updated regularly to remain current. The regulation establishes the pre-authorized list as all tests, procedures, and treatment consistent with the Guidelines, except for 12 specifically identified procedures. The comments state that an additional six weeks of indemnity benefits will be provided during the additional 45 days, this change will prevent proper case management and meaningful application of the Guidelines, will prevent return to work, and will result in additional IMEs. Suggestions were received to retain the current 45 day time period and to reduce it to 30 days. It was not the intent of this provision to state that physicians have 90 days after the examination of a claimant to submit a medical report. Rather, the intent was to require follow-up visits with the physician at medically necessary intervals, for which the physician would submit a medical report, except that the intervals between follow-up visits can be no more than 90 days. To ensure the provision is not misinterpreted, it has been reworded. Physicians have complained that they are forced to examine claimants when it is not medically necessary in order to file a medical report every forty-five days, which results in medical reports that are no different than the previous report, because nothing has changed medically. In addition, the provider is entitled to a fee for the office visit, which increases costs. By requiring reports only when a visit is medically necessary, but no more than ninety days apart, fewer unnecessary office visits will be scheduled and costs reduced. Numerous comments were received about the medical treatment guidelines Guidelines themselves. The only changes to the Guidelines were to correct typographical errors, misspellings, and formatting, insert words that were accidentally left out, and to correct one section so it is now clinically feasible. Details on the changes to the Guidelines are set forth in the full assessment. A number of the comments received challenged the statement that the Guidelines are evidence-based or took issue with the treatment guideline chosen as the base document. The Guidelines were developed by an advisory committee

comprised of representatives from the Insurance Department, Board, and Labor Department, and highly qualified and respected medical professionals selected by labor, business, and the Insurance Department. The advisory committee was created to develop the Guidelines as directed by former Governor Spitzer in a letter dated March 13, On December 3, , medical treatment guidelines for the neck, back, shoulder, and knee that all providers would be required to use when treating injuries to those body parts were sent to the Chair. Consideration was limited to guidelines used for treating work-related injuries and illnesses. The guidelines chosen are nationally recognized medical treatment guidelines used for treating individuals with workplace injuries. After the recommended guidelines were submitted to the Chair, various entities submitted comments and met with the Chair to discuss the guidelines. On August 13, , the Chair issued a notice advising the public that comments on the Guidelines would be accepted through September 9, Comments received after September 9th and comments received that were not incorporated, would be retained and considered during the regular process of review and updating of the Guidelines. The Medical Director and Board staff reviewed the comments, and on January 19, , revised guidelines were released. Final guidelines were released on June 30, Many of the comments requested changes to the Guidelines based on literature and offered evidence in support. However, as just explained a formal comment period on the Guidelines was conducted in , which resulted in revisions to the Guidelines. It is recognized that medical science and practice will change over time and the Guidelines must keep pace with these changes. The Chair will implement a process to review and critique available medical literature and update the Guidelines as indicated. The comments that requested changes to the Guidelines recommendations based upon literature provided will be considered at that time. In addition, some of the requested changes were submitted and considered for the revised Guidelines released on January 19, The specific suggestions are addressed in the full assessment of public comment. These letters expressed concern about needing treatment outside the Guidelines which is addressed through the Variance process, and support for the comments and recommendations of the chiropractic profession which are fully discussed in the full assessment. Approximately of the form letters were from individuals stating they were chiropractors authorized to treat claimants. Finally, the letters express support for the comments of the New York State Chiropractic Association. Approximately form letters were submitted by patients receiving physical therapy services. The letters express two main concerns, reimbursement and access. The first concern regarding reimbursement is not the subject of this rule. The second concern relates to the maximum number of visits or modalities and the concern it will limit potentially needed care, which is addressed through the variance process. Approximately of the form letters were submitted by physical therapists and discussed three main concerns: As stated above, the guidelines chosen were picked because they were the best of the guidelines available for work related injuries. As mentioned above, if additional visits or modalities are necessary then a variance can be requested by the treating physician ordering such additional visits or modalities.

Chapter 5 : Adoption and Implementation of the Medical Treatment Guidelines - Summary of Public Comm

Excerpt from Synopsis of Medical Treatment The writer Wishes here to express his deep appreciation of the debt which he owes to his teachers in medicine, of their kindliness to their pupils and of their humanity to their patients.

Chapter 6 : Tuskegee syphilis experiment - Wikipedia

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Chapter 7 : Treatment Summary | Journey Forward

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Chapter 8 : Minorâ€™s Rights to Consent to Medical Treatment â€“ Summary | Children and Family Law D

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Chapter 9 : Synopsis of Medical Treatment

The concept of a written treatment plan template and summary provided to the patient and referring physicians came as a complete surprise to the physicians in my practice. Treatment plans and summaries were originally piloted in our office as part of a voluntary effort with ASCO.