



Patient Safety America Newsletter

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Question: Among patients inappropriately admitted for syncope, what percent experienced an adverse event?

- a) 5% b) 10% c) 15% d) 20% e) 25%

High Value Care for Cancer Screening

The *Annals of Internal Medicine* just published a guideline called “Screening for Cancer: Advice for high-value care from the American College of Physicians.”¹ Consistent followers of the debate on cancer screening will know that decisions about whether to be screened or not is anything but simple. Furthermore, there is often more than one way to be screened if one accepts the need for screening of some kind. The same journal simultaneously published “Summaries for Patients” page that will orient patients on the complexity of screening choices, but does not give specific guidelines.²

The patient page gives five concepts: 1) screening may involve more than one test, 2) not all cancers are the same, 3) not all patients are the same, 4) screening can cause harm to many patients, and 5) it’s not easy to determine the value of screening procedures. Without further elaboration here, I would encourage you to read this page.

The article points-out that low-value screening is commonplace. As examples of low value screenings in the recent past, 1 in 5 women under the age of 39 receive a physician recommendation for mammography, and half of women over 80 receive cervical cancer screening. More than 2/3rd of women with no cervix receive a Pap test and more than a million women receive screening for ovarian cancer. About half of men received PSA screening even though they were in

the 75-79 year age bracket. Colorectal cancer screening occurred more frequently in 60% of patients than guidelines recommend.¹

How does one avoid low-value cancer screening? The easiest way, and perhaps the least effective is to ask your physician which guideline he is following when he recommends screening for you. After an awkward pause, he may actually provide you a clear answer. You could follow up his answer by asking why he selected that specific guideline over the others that have been published. Another important question you must ask yourself is whether you are at higher than average risk for a specific cancer. If you are, then more targeted screening is going to be appropriate.

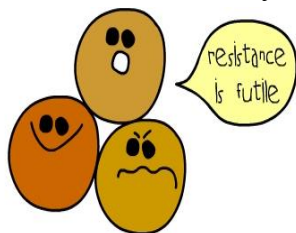
The cautious and informed patient will get a copy of the full article in the *Annals of Internal Medicine* and read it carefully.¹ It is available free of charge. The article provides an informative table in which screening recommendations from various professional societies have been compiled. It’s fairly easy to pick out the areas of controversy. One thing I like about the recommendations from the American College of Physicians is that it uses terms like “shared decision making” or “patient preferences” in areas where there is uncertainty about screening. However, you are not going to be able to share in decisions or make informed decisions about your preferences if you do not know where to find applicable guidelines.



Reducing Surgical Site Infections

Surgical site infections (SSIs) are the most common reason for hospital readmission after surgery. In cardiac and orthopedic surgeries the most common infection is by *Staph. aureus*. Especially when a joint has been replaced, these infections can be devastating.³ A large group of investigators set out to determine if a bundle of interventions before orthopedic or cardiac surgery could reduce the frequency of SSIs.⁴ The interventions included nasal screening for certain bacteria, doses of antibiotic as appropriate, and bathing with chlorhexidine-gluconate before surgery.

Before the bundled intervention the rate of SSI in the 20 participating hospitals averaged 36/10,000 surgeries and after the intervention the rate was 21/10,000 surgeries. This was termed a “modest” reduction by the investigators.⁴ But as



Methicillin-resistant
Staphylococcus aureus

pointed out by the commentary on this study, the reduction is clinically meaningful for each patient in which the SSI was prevented.³ What is disheartening to me is that after a 3-month phase in period, only 39% of the time was there full adherence to the bundle. This is a reflection of the difficulty of changing medical practices.

Informed Consent – Really?

One of my pet peeves in medical care is the way information is conveyed to the patient to enable her informed decision about invasive medical care. Obviously, the readability of informed consent forms is part of the equation leading to a wise decision by the patient. A brief study of European informed consent forms to participate in a clinical study were assessed for their readability.⁵ The study involved forms used in the U.K., Switzerland, Germany and Austria. A few of the forms, particularly in the U.K. were readable by those with a secondary education, but most others required a tertiary education to grasp the meanings. Since one of the authors was a lawyer, it was pointed out that forms that supersede the reader’s ability are going to

be legally invalid. It’s unclear to me who would enforce this legal stipulation.

There is a clear message for patients who have agreed to participate in a clinical study, or are simply undergoing a common, invasive procedure: **get the forms you are going to sign ahead of time and ask questions until you understand the forms. Write down your answers to your questions and make sure your doctors know you are doing this. You only get one body to get through this life, so make certain you understand the reasons that you are allowing strangers to invade it with scalpels and/or powerful drugs.**

Selling Harm in Patients with Low-risk Syncope

Syncope is defined in lay terms as fainting and recovery. I am particularly sensitive to this term because my son died as a result of uninformed and unethical medical care after he experienced syncope while running. He self-recovered from his first syncope, but even after extensive medical evaluation, he died as a result of his second syncope episode less than a month later. His was never low-risk syncope; indeed, syncope while exercising is termed a “near death” event.

In the less-is-more section of *JAMA Internal Medicine* a team of five MDs asked how often unnecessary hospital admissions occur when low-risk syncope occurs.⁶ There is something called the “San Francisco Syncope Rule (SFSR)” that was published in 2006 to identify patients that were unlikely to benefit from hospitalization following syncope.⁷ The authors point out that hospital admission can result in adverse events and cascades of irrelevant testing.

Low-risk syncope is one receiving a “0” rating on the SFSR scale.



The authors found 72 hospital admissions for patients with a SFSR score of 0 over a period of 3 years in a tertiary-care hospital. Their average stays in the hospital were just short of 2 days and they received an average of 11 tests. In the 72 low-risk patients admitted, the records showed 11 adverse events. Four of these were serious – delirium, transfusion error, hypoglycemia, and fall.

Additional adverse events included medication error, and complications from catheter placement.

There is a clear message here: if you are looking after a person who has fainted and been taken to a hospital, ask what their SFSR is before you allow them to be admitted. The doctors may be taken aback at your question. Use your I-Phone to show the rating system to them if they are not aware of it (see the Results section of the following article from 2004: [SFSR](#) Just declare that you worry about potential harms that could occur when an admission is unnecessary.

Darn Double Chin

Many of us want to look like the models we see in glossy advertisements and fashion magazines. One of the great stumbling blocks to that appearance for many of us is a double chin. Much to my amazement, the FDA has approved a drug for the treatment of such things.⁸

Before you get highly excited about this treatment, you need to hear how the drug is used and what its side effects are. The drug is called Kybella. It destroys fat cells when injected into them. Treatment could involve up to six sessions of 50 injections each. Side effects include nerve damage in the jaw leading to facial muscle weakness and trouble swallowing. Less severe side effects include swelling, pain, numbness and hardening of the area treated. The drug is not approved for reducing fat anywhere else in the body; but never forget that once a drug is approved for any specific purpose, physicians can prescribe it off-label for any condition.

A YouTube video purports to give exercises that can result in reduction in double chins and other improvements ([double chin gone](#)). The results should appear in 30 days. Good luck.

Evidence-based Medicine – Not

The *JAMA* featured an interview of a Canadian MD who 25 years ago came up with the label “evidence-based medicine,” referring to a physician’s ability to find the best clinical evidence, interpret it correctly, and apply it to care of their

patients.⁹ When asked during the interview how well US medical schools are doing in teaching evidence based medicine, he responded, “Better and better, but still a long way to go.” He cites evidence that medical schools are not doing a good job of teaching evidence-based medicine. He goes on to point out that physicians these days must take into account the preferences of their patients. I would point out that if I as a patient have a tough decision to make, I want my doctor up to date on the evidence that applies to my condition. It seems that that may often not be the case.

Professionalism of Doctors

A series of viewpoints, mostly from MDs, on the status of their profession was published recently in the *JAMA*. From the patient’s point of view, I feel that some of the thoughts physicians have about themselves are not balanced. Herein I’ll compile a collection of points that I feel physicians need to be more aware of if they are to continue to claim to be professionals. Here’s Merriam-Webster’s definition of professional: “**(1)** *characterized by or conforming to the technical or ethical standards of a profession* **(2)** *exhibiting a courteous, conscientious, and generally businesslike manner in the workplace.*” It seems to me that both parts apply to medicine. Doctors must have up-to date technical knowledge, be constrained by patient-centered ethical standards, and behave in a civilized way when interacting with other providers and with patients.

Herein I’ll rely heavily on an editorial summary written by three MDs about the collection of viewpoints.¹⁰ The editorialists point out that the medical community expects to remain self-regulating given its professional status. However, this could change as some current trends toward outside regulation of “naughty” (my word) industries such as the banking industry, have been undertaken.

Let’s start with state medical boards. These entities exist to protect the public and ensure that only qualified physicians practice medicine. Public participation and transparency, two facets of an effective board listed in the editorial, are mere shams. This has been well documented by my Safe Patient Project colleague Yanling Yu, PhD.¹¹ The editorialists do admit that these boards need to be more proactive in safeguarding the public. The Canadians have gone to a system that actually does

proactively identify deficiencies in clinical competence to prevent patient harm. One facet of this process that I am aware of is the 360-degree reviews conducted in several Canadian provinces. By this process physicians are *anonymously* made aware of the deficiencies in their performance as viewed by their service leaders, colleagues, subordinates, and patients.

One viewpoint suggests that physicians must be committed *as individuals* to self-regulate according to the tenets of professionalism. Given the definition I found above, this is a naïve expectation. Do we really expect individual doctors to eschew the perverse incentives to make as much money as possible, to deny human nature and admit mistakes, and to spend inordinate amounts of unpaid time



maintaining their clinical competency? Give me a break – this is not happening, nor is it going to happen soon

under self-regulation. One viewpoint suggests that the “negative effects” of money in medical care has distorted judgements about what is best for patients.

One important question is whether professionalism can be taught, and once taught, can it be maintained. In my opinion, medical school applicants must be screened for demonstrated work that places others at the center of their efforts with no focus on themselves. Professionalism in medicine requires abandonment of self-interest to the benefit of others in need (i.e. the patients). I do not think this can be taught unless there is at least a kernel of selflessness in medical school students.

Another facet of medical professionalism – continuing medical education - has mostly failed to improve physician performance and is not based on any scientific demonstration of value to clinical practice.¹⁰ It’s no wonder. In Texas only 1% of doctors are screened each year to determine if they have performed their 24 hours of annual continuing medical education. Is this lax practice ever going to assure the Texas public that their physician is consistently able to deliver competent medical care?

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Answer to question this month: c) 15% is the best answer; the actual rate is 13%, reference #6