PSA

Patient Safety America Newsletter

May 2019 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: Which one of the following oxygen saturations is not optimal for an acutely ill patient?*
a) 93% b) 94% c) 95% d) 96% e) 97%

New Shingles Vaccine

An editorial in the *Annals of Internal Medicine* described an economic analysis showing cost effectiveness for a new vaccine. Herein, I am most interested in the performance of the vaccine. I'm not one to charge off getting vaccines, especially new ones that may offer no advantage over old ones. Following FDA approval in October, 2017, a recombinant vaccine for herpes zoster (shingles) called Shringrix, has been available to the public. Ideally, it is given in 2 doses a few months apart, whereas, the old vaccine was given as a single shot. The new vaccine is quite effective. In persons over 50, the incidence was reduced by 97%. In those over 70, the incidence was reduced by 90% and in those over 80, the incidence was reduced 89%. The former, single-dose vaccine was only 37% effective in persons 70 or more years old. Not much good.

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This is all well and good, but the new vaccine may knock you on your butt for a few days. I have heard this anecdotally and it is consistent with the CDC warning: 'Most people got a sore arm with mild or moderate pain after getting Shingrix, and some also had redness and swelling where they got the shot. Some people felt tired, had muscle pain, a headache, shivering, fever, stomach pain, or nausea. About 1 out of 6 people who got Shingrix experienced side effects that prevented them from doing regular activities. Symptoms went away on their own in about 2 to 3 days. Side effects were more common in younger people.'

The message here is that if you want to have this vaccine, then do not get the shot a day before your grandkids show up ready to play. You may be in bed filled with pain relievers and feeling like a truck ran over you. I wish they would develop a vaccine us wimps would tolerate.

Perspective on Informed Consent

I must admit that I see informed consent, or lack thereof, from the patient's perspective. I know it is rare that all the questions a patient may have are answered. Indeed, in many situations, the patient does not even know what to ask. A young woman physician describes from her heart how the challenges of delivering informed consent have influenced her early in her career. She wrote first about being handed the task, as a mere surgical trainee, of obtaining consent from a patient when she knew very little about the proposed surgery. She quickly searched for information about his surgery, showed it to the patient, but he remained reluctant to consent to surgery. She proposes that physicians in training (residents) be given more training on how to deliver informed consent if they are going to be expected to do it.

It seems that in the night after her attempted informed consent, the patient began bleeding profusely, but since he had looked at the material the young doctor had left and signed the consent form in her absence, the surgery was able to go ahead. He was thankful for her help. She reflects that she will, when she is the senior doctor, make sure the patient

has the information he needs to consent, but, and here is the rub, there are time constraints. And so, she recalls a time when she gave an over-simplified, inadequate explanation to a patient who was about to have highly invasive, potentially disfiguring cancer surgery.

Doctors and patients must find a place where they can meet together to do shared-decision making. I know that the AMA once declared in its rules for informed consent that the physician doing the surgery must obtain the patient's consent. That disappeared from their website about 2010. These days there is debate about who is responsible for informed consent and to whom it may be delegated.

Harm from Low-value Procedures

Our healthcare industry is in the business of selling procedures when it is built around fee-for-service. Doctors, surgical centers, and hospitals deserve a decent pay for their work, but when pay is made from doing procedures that have little value, then such practices should be stopped. A team of investigators looked at the consequences to patients of performing low value care. They asked how often a low-value-procedure resulted in a hospital acquired complication (HAC) that harmed the patient. They identified 9,330 instances of low-value care in 7 categories in the years 2014 to 2017 in New South Wales, Australia that led to a HAC.

Of the 7 types of low-value care, the ones with the highest portion of HACs were from the following procedures: spinal fusion (7%), endoscopic repair of abdominal aortic aneurysm (15%), carotid endarterectomy (8%), and renal artery angioplasty (8%). The most common HAC was hospital acquired infection at 26% of all HACs. The median length of stay for patients experiencing a HAC was twice the length for those who did not experience a HAC.

It is one thing to be harmed by a procedure that was clearly appropriate for preserving one's health or life, but it is another matter to be harmed by a procedure that never was likely to do one any good. Tying this to my first summary above, such low-value procedures can only be sold to patients who were denied the information they need to make an informed decision about their medical care. What patient is going to agree to a procedure when their clinician tells them that what they need is a procedure that is unlikely to help them and has a substantial risk of infection or other complication?

Physician Trust of Colleagues

During preparations for a discussion group among physicians, 16 participants were asked about their level of trust between and among their colleagues. The responses were sorted into three categories as follows: co-management of patient care, interactions among medical specialists, and disrespectful behavior. Four negative stories were described in the first category and one positive story. Three stories in the second category were negative, and four stories were negative in the third category.

Selected examples of negative trust were as follows. disparaging comments to the patient from one doctor about his colleague's poor skills, effectively 'triangulating' the patient between two doctors of strongly different opinions. Another involved an attending physician who commented that his colleagues working in the community were not 'real doctors." Finally, an attending physician once refused to support a resident who was a victim of a disrespectful patient.

The writers call for more research on the ways physicians can attain trust in one another. These are about the same as how we ordinary people gain trust in each other: know mistrust has consequences, value differences of opinion, and recognize patterns of respect in each other.

This investigation reminds me of someone in my family who needed a specialist of some sort. Her internist indicated that there were 3 specialists he would not recommend. Then the question becomes this: If I were a physician that needed to refer my patient to a specialist, and I had good reasons to distrust a few of them, is it ethical to deny that information to my patient? I also recall that my mother's care was triangulated between her cardiologist and nephrologist. Her cardiologist recommended a medication, but her nephrologist declared to my mother, "Don't you dare take that medication." Ironically, these two doctors were husband and wife.

Patient and Physician Trust

Many Americans do not trust doctors. In a survey of 23 major countries, only Chile and Poland ranked lower than the United States in the level of trust their citizens hold for their doctors. Many theories have been put forth to explain this situation. It's complicated.

What about the other direction? To what extent should doctors trust patients. Isn't this a prerequisite for shared-decision making? Three experts examined this question in a *JAMA* viewpoint article. Physician trust of patients depends on whether they believe the information provided by the patient, and whether there may be a goal to manipulate the physician into prescribing medications that the patient wants but does not need.

We know that patient information improves diagnosis, but doctors often miss an opportunity to listen to patients because of their tendency to construct a diagnosis before the patient is through with information delivery. Trusting patients may make the physician less stressed with his responsibilities. It also seems that when doctors trust their patients, patients are more likely to reciprocate that trust. The writers note that the physician must demonstrate trust to the patient, not just assume the patient perceives trust.

In many ways this article points toward a draft manuscript I just reviewed involving the strategies physicians use to reduce arrogance. It seems to me that physician's lack of arrogance is going to directly contribute to trusting their patients. They must see their patients as trusteed partners in shared-decision making. Of course, there are situations where the patient may be untrustworthy; for example, a patient with cognitive decline may be unable to recall important information or may be unable to describe his symptoms accurately. This is why a trusted family member makes a good addition to the process of shared-decision making in many cases.

Where is the Recovery in a Hospital?

A woman internist wrote about the technically sound medical care her seriously ill brother received, but ultimately he died. Why? On reflection, she writes that what was missing during his care was a plan for her brother's recovery from his illnesses. She was present much of the time during his care, but felt unable to steer it toward improving his nutrition and strength. She said that she felt like she was watching an 'express train of technology' that was not targeted to making her brother recover.

What her brother needed on reflection was a rehabilitation specialist that could lead a team of experts to focus on nutrition, psychological needs, and physical therapy. This person would coordinate care, keeping foremost in mind the question that must be answered by the technology folks – is this further treatment going to contribute to his recovery? I'm not going to dig into the various trials this poor man endured, but in the end, when his kidney function was lost, he simply gave up wanting to live. I have to salute the heartfelt story his sister told. It is a lesson for hospital clinicians and patient advocates. **Where is the plan for patient recovery and who is directing that plan?**

Learn Nutrition, Please Doctor

Three MDs wrote their view in the *JAMA* on the failure to provide nutritional training during medical education. This makes a nice follow-up to the summary above. The authors list 4 reasons that nutrition education should be a priority in physician education.

- Poor quality diet is the leading cause of death in the U.S.
- Healthcare is shifting from disease management to health promotion
- Physicians need to help patients manage diverse information on nutrition
- Nutritional knowledge will help physicians improve their own health

The authors recognize that medical school curricula are already bulging with the growth of medical knowledge. They proposed making nutrition considerations part of already existing elements of the curriculum. For example, a unit on hypertension could well include nutritional and lifestyle changes to lower blood pressure.

The authors conclude with a note that paying attention to nutrition is good medicine and it is also value-based medicine. In my opinion, therein may lie the basic problem, which is that the healthcare industry is going to make less money if it offers value-based care over revenue-based care.

Oxygen Therapy

Many acutely ill patients have some tubes hanging just below their noses with tubes running up inside. These, as most know, are to enrich breathing air with oxygen. The goal is to keep the patient's oxygen saturation up to where it should be, given that the patient has problems doing this on their own. The question on the table is what is high enough oxygen saturation. A new guideline noted in *Annals of Internal Medicine* and originally published in *Therapeutics*, aims to declare the level of saturation appropriate for optimal care. The summary paper notes the following: 'Oxygen toxicity has long been recognized. Despite its potential for absorption atelectasis [lung collapse], worsening hypercapnia [carbon dioxide retention], and oxidative stress-induced lung injury [potential inflammation and scar-tissue formation], prevailing practice in acute illness is to use oxygen liberally, regardless of hypoxemia.'

The guideline specifies that oxygen saturation in the blood, which is easily monitored, should not be above 96% and should be kept at or above 93% based on solid evidence. Victims of heart attack or stroke should not have oxygen started until their saturation drops below 90%. If you are called to advocate for a patient in an acute care situation, keep an eye on oxygen saturation levels. A few years ago when my dad was hospitalized after a fall, the hospital seemed determined to keep his oxygen saturation well above 96% until I reminded them that this was not optimal. Three times I had to ask his doctors to lower the level of oxygen supplementation being delivered in his nasal tubes. He was off of oxygen much sooner than they expected.

Mesh Implants for Women

In a news & analysis article in the *JAMA*, a writer examines expert opinion on the pros and cons of using FDA-approved mesh implants to treat stress urinary incontinence in women. Some consider it the 'gold standard' treatment and others consider it scandalous. Proponents argue that mesh failures are due mostly to inexperienced surgeons. There is an alternate treatment that does not use mesh, but its comparative effectiveness and safety have not been elucidated. One physician is not in favor of banning mesh slings, but he insists that women should be better informed by their doctors before deciding to have this treatment. In the meantime, the FDA has asked manufactures to quit selling mesh for transvaginal pelvic organ prolapse.

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Answer to question: e) 97% is too high creating potential for oxygen toxicity