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<http://PatientSafetyAmerica.com>

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**Question:** Excluding deaths from COVID-19 and pneumonia, how many Americans had died of COVID-19 alone as of November 14, 2020? A) 200,000 B) 230,000 C) 260,000 D) 290,000

## Safer Healthcare for You

Evidence-based medical guidelines (EBMGs) are designed to make the treatment patients receive consistent and better than if individual clinicians simply do what they happen to think best. All patients should be aware that EBMGs exist and should always ask about ones that may apply to their care during the process of shared decision-making. Variations in treatment should be based on patient preferences rather than deviations from guidelines. However, [two experts opine](#) that present guidelines tend toward the view that more treatment is better treatment. The authors cite a study in which ‘deintensification’ of EBMG treatment is better treatment. The other important point that patients should know is that there will likely be uncertainties in the guidelines.

Overtreatment ‘domains’ addressed by the experts included the following: a diagnosis that leads to unwarranted, downstream activity, unnecessary treatment, and futile or dangerous drug prescribing. The writers note that primary care physicians may be placed in a difficult position if they feel that the intensity of care needs to be reduced in a patient seeing overtreating specialists. Deintensification is not easy for clinicians. Patients must be prepared to ask about less intense treatment of their illnesses. One example I would offer is [overtreatment](#) of hypertension in hospitalized patients.

A recent article in *Implementation Science* caught my eye because it rated the quality of 161 medical guidelines according to criteria pertaining to 1) the quality of the development process, and 2) the quality of justification for the recommendations. The large team of [investigators](#) used a well-vetted tool for the first assessment and a tool-in-development for the second. They engaged 322 ‘experts’ from 51 countries in evaluation of the guidelines. The maximum score was 7 points. The total average recommendation score was only 4.2. ‘Evidence’ scored a 5.5 and ‘clinical relevance’ a 6.0. Guidelines developed by the governments of the U.K. and Canada, as compared to the U.S., had significantly higher scores. Guidelines developed in other countries or by non-governmental entities also scored lower. Scores pertaining to the quality of the development process were highest for ‘scope and purpose’ and ‘clarity of presentation.’ There appears to be plenty of room for improvement.

If a guideline is being applied to your care, you may want to determine if it has been scored for quality. A list of USPSTF screening guidelines is available for those scoring an A or B grade for quality: [USPSTF](#). A source for clinical-practice guidelines is the [National Guideline Clearinghouse](#).

The patients whose lives we save can never be known. Our contribution will be what did not happen to them.

We will know that mothers and fathers are at graduations and weddings they would have missed, and that children will know grandparents they might never have known. Holidays will be taken, books read, symphonies heard, and gardens tended that, without our work, would never have been.”

– Donald M. Berwick, MD, MPP

IHI Founder, to the quality improvement and patient safety community convened at the 2004 IHI National Forum in the United States.



## Gateway to Shared Decision-Making

There are few factors more important than the skill of the clinician and the relationship she has with her patient when that patient is considering low-dose (LD) CT scanning for lung cancer. [Two investigators](#) asked if the effectiveness of shared decision-making was affected by the specialty of the clinician and by a relationship established between patient and clinician. They examined the records of 11,700 patients ages 55-80 years old that were offered a LDCT scan for lung cancer screening in 2016-2018. They assessed whether a LDCT scan was performed within 3 months of the initial offer to perform one. The overall percentage of patients taking one was 64%. Broken down by clinical specialty, the percentages were as follows: radiologists 93%, nurse practitioners 80%, pulmonary specialists 56% and family physicians 54%. Only 55% of the patients that had seen the clinician in the past year decided to have a LDCT scan, whereas 75% of those that had not had a visit in the past year decided for a LDCT scan.

The study was a 'research letter,' which means that investigation into the cause of large differences were not performed. One would expect that if a consistent shared decision-making process were undertaken, the percentages would have been much closer. The first question I would ask is whether a [LDCT decision aid](#) was used as part of the shared decision-making discussion. This would be a key tool to making outcomes more uniform. When considering cancer screening of any type, the patient should ask their clinician if a decision aid is available.

## Artificial Intelligence in Radiology

As annoying as it is for us old timers, highly trained algorithms are beginning to take over where a trained expert used to discern the findings. A [huge team of investigators](#) asked if a well-trained artificial intelligence (AI) algorithm could compete with third year residents in making diagnoses from frontal, chest radiographs. The AI algorithm was trained on a set of 342,000 radiographs. Ultimately the AI algorithm did at least as well or slightly better than the third-year radiology residents. The authors suggest that a well-trained AI algorithm is suitable for *preliminary reading* of radiographs.

## Disappearing Physical Exam

A [primary care doctor](#) with 15-years of experience discussed what is lost to him and his patients when the physical examination of a patient is not thoroughly performed. With the dropping of a physical exam from the annual physical requirement for Medicare patients without new symptoms and the advent of telemedicine, the physical examination is being pushed aside. On some occasions the physical exam reveals health conditions that are asymptomatic. There is a closeness that comes with listening to the heart of another person and to listening to their story while touching them.

Telehealth has forced a new paradigm that causes the author to adapt his thinking but his comfort level with all this has not caught up. Even when the pandemic is behind us, there will be much more telemedicine than there was before the pandemic. Patients should be prepared to adjust to this situation and respect the reality that their doctor may also be in a time of adjustment.

## Fraud and Abuse Laws in Healthcare

A [couple of experts](#) (JD and MD) opine that fraud and abuse laws need modernizing to better address the inducements that the medical industry may implement to gain income. Inducements may impel delivery of value-based care or its opposite, delivery of care sensitive to monetary gains by physicians or drug and device companies. The authors opine that current laws do not have the power to induce correct responses that improve quality of care in a cost-effective way.

One example they describe is the payments drug companies make to reduce out-of-pocket costs for selected drugs. Such inducements enable drug companies to keep prices in general high and capture market share. An example is cited in which cardiologists have a strong tendency to use devices made by manufacturers that have given them payments for various activities such as expenses associated with speaking at a meeting. In my opinion, stronger laws governing informed consent and shared decision making would curtail many of the costly inducements. Disclosures to the patient should include all options for invasive medical care, and their benefits and risks. It should also include the risks and benefits of doing nothing.

## Reduce Falls in Hospitals

Falls in hospitals are common causes of patient harm and may be costly in terms of prolonged hospital stays and treatment of injuries. It seems that most falls are due to patient non-compliance with protocols designed to prevent falls. The responsibility for preventing falls resides with the nursing staff. The question was whether better [engagement of patients](#) by nurses in developing and using a fall-mitigation kit would make a difference in the risk of falls.

Through a 5-step process the investigators devised a kit involving laminated posters, integration into the electronic health record, or a bedside screen. The hospitals involved could select the mode they wished to use from the kit. The rate of falls per 1000 hospital days was compared before and after implementation of the intervention. Nurse champions were critical to engaging patients in complying with the changes. The cumulative data covered 278,000 patient days in 14 medical units. All falls fell from 2.9/1000 days to 2.5/1000 days. Injurious falls fell from 0.73/1000 days to 0.48/1000 days. The kit seemed to work.

## COVID Articles and Links

### To Mask or Not

[Three MDs](#) from the U.S. National Institute of Allergy and Infectious Diseases wrote about the value of wearing masks as part of the low-tech strategies to prevent spread of the SARS-CoV-2 virus. Other low-tech measures include social distancing, avoiding crowds, and hand hygiene. Perhaps the best data on the value of using masks comes from a study in a U.S. medical center where the impact of a mandate for all workers and patients to wear a mask reduced the virus positivity rate in workers from 14.6 to 11.5 percent.

The Centers for Disease Control and Prevention ([CDC](#)) has issued guidance that all people over 2 years old should wear masks in situations where exposure is possible. New guidance as of November 12, 2020 indicates that masks protect those around you from exposure to any virus you exhale, *and* they also protect you from virus aerosols released by others. Mask wearing is not going to totally prevent anyone from contracting the

disease, but it is a key component of effective, low-tech measures to slow the spread of the virus.

### Crowding in Nursing Homes

It is intuitive that crowding in nursing homes is going to facilitate the spread of any contagious, infectious agent. A team of [Canadian experts](#) sought to determine the impact of crowding in nursing homes on the spread of SARS-CoV-2 virus in nursing homes in Ontario. The study looked at records from more than 600 nursing homes involving about 79,000 patients who were residents in April and May of 2020. Among the residents, 5,600 contracted COVID-19 and 1452 residents died of this infection. Infections were not evenly distributed; 86 % of the infections happened in 10% of the nursing homes. A crowding index was used that depended heavily on the number of beds per room. In general, low-crowded facilities maintained one bed per room, whereas the high-crowded facilities had 4 beds per room. The incidence of infection in high-crowded homes was 9.7%, whereas in the low-crowded homes it was 4.5%. Death from COVID-19 was 2.7% in high-crowded homes and 1.3% in low-crowded homes. Their estimate suggested that converting all 4 beds/room facilities to 2 or less beds/room would have saved about 260 lives.

### Anti-science Americans

An MD [writes his opinion](#) about how Americans tend to be misled by those opposed to wearing masks, by baseless conspiracy theories, by fear of vaccines, and by elected persons pushing unproven drugs. We have reaped what our anti-science tendencies have sown – we are 4% of the world's population and have 20% of the world's COVID deaths. He asserts, rightly I believe, that our low science literacy is behind this national characteristic. He suggests that knowledge of neurodegenerative disorders might shed light on how belief in what is not real is maintained. In certain types of dementia, the victim holds wildly unrealistic perceptions. Often this depends on altered sensory perceptions. I have witnessed what he is talking about, so to this point I agree with the misperceptions of someone with dementia, but how does that relate to anti-science?

The MD posits that those who disbelieve science have acquired 'faulty systems for monitoring and evaluating scientific information.' Americans must be taught to weigh all sides of a scientific argument to discern what is true. He calls upon politicians to support science-based policies. I would have added that physicians making public declarations outside their expertise must be held accountable for unscientific statements. One example is Scott Atlas, MD, a neuroradiologist; [CDC criticizes White House medical adviser's discredited mask claim \(yahoo.com\)](https://www.cdc.gov/media/releases/2020/s110320-atlas-discredited.html). There have been suggestions that his medical license should be revoked; [Letter: The many reasons to revoke Atlas's license \(concordmonitor.com\)](https://www.concordmonitor.com/2020/11/03/letter-the-many-reasons-to-revoke-atlas-license/).

## COVID Sites and Links

Millions with COVID could be denied coverage if the ACA is ruled unconstitutional:  
[https://www.commonwealthfund.org/blog/2020/millions-young-adults-covid-infections-could-be-denied-health-coverage-if-affordable-care](https://www.commonwealthfund.org/blog/2020/millions-young-adults-covid-infections-could-be-denied-health-coverage-if-affordable-care-act-is-ruled-unconstitutional/)

What is at stake in the presidential election:  
[https://www.commonwealthfund.org/blog/2020/health-care-2020-presidential-election-whats-at-stake](https://www.commonwealthfund.org/blog/2020/health-care-2020-presidential-election-whats-at-stake/)

Cost to Medicare and Medicaid beneficiaries will be covered:  
<https://thehill.com/policy/healthcare/523281-medicare-medicaid-will-cover-costs-of-future-covid-vaccine-under-new-policy>

Inside the fall of the CDC thanks to the White House (ProPublica):  
<https://www.youtube.com/watch?reload=9&v=-L0gMy5OZfM>

Biden's plan to combat COVID-19:  
<https://www.npr.org/sections/health-shots/2020/11/08/930887069/hold-president-elect-biden-has-a-plan-to-combat-covid-19-heres-what-s-in-it>

Knowing COVID test was flawed, CDC released it anyway:

<https://www.npr.org/2020/11/06/929078678/cdc-report-officials-knew-coronavirus-test-was-flawed-but-released-it-anyway>

FDA authorized monoclonal antibody treatment for COVID: <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-monoclonal-antibody-treatment-covid-19>

What are monoclonal antibodies?

<https://www.livescience.com/what-are-monoclonal-antibodies-coronavirus.html>

High viral load at hospital admission associated with higher mortality:

[https://www.seattletimes.com/seattle-news/health/higher-viral-load-more-deadly-for-covid-19-hospital-patients-uw-analysis-finds/?mkt\\_tok=eyJpIjoiT1RVMVltUTBNemN5T0RVdyIsInQiOiJWXC9EMVhmYkhwY01UcndtSjNjbDJ3VXVKTkdhZBGWTVCU3J2MGVYam56VUtLTkdsWE9hNIBsXC8xdWxYQzRWMnZYTkZ6VG1YWUJUM2VJazloSGIFU29SOWMrZ3E5eTJXV1FvR2ZHVmdmd2VHWDV2NGRtcktXbjJlMmFwTllyOHBMSCJ9](https://www.seattletimes.com/seattle-news/health/higher-viral-load-more-deadly-for-covid-19-hospital-patients-uw-analysis-finds/?mkt_tok=eyJpIjoiT1RVMVltUTBNemN5T0RVdyIsInQiOiJWXC9EMVhmYkhwY01UcndtSjNjbDJ3VXVKTkdhZBGWTVCU3J2MGVYam56VUtLTkdsWE9hNIBsXC8xdWxYQzRWMnZYTkZ6VG1YWUJUM2VJazloSGIFU29SOWMrZ3E5eTJXV1FvR2ZHVmdmd2VHWDV2NGRtcktXbjJlMmFwTllyOHBMSCJ9)

Light at the end of the COVID tunnel:  
<https://www.kentucky.com/opinion/op-ed/article247262694.html>

Great COVID tracking site (state by state): [Tracking Our COVID-19 Response - covid19strategy.org](https://www.covid19strategy.org)



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Answer to question: Best answer is (B), 234,000. Source:  
<https://www.statista.com/statistics/1113051/number-reported-deaths-from-covid-pneumonia-and-flu-us/>