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<http://PatientSafetyAmerica.com>

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*Question: State medical boards ensure that doctors do not engage in sexual misconduct with patients.
TRUE or FALSE*

Adverse Drug Reactions after Hospital Discharge

Drugs can be a powerful invasion of your body. One of the most critical times for harm from drugs happens after discharge of patients following hospitalization. Roughly 1 in 5 older adults will have an adverse drug reaction after discharge. Two experts wrote an invited commentary, [Adverse Drug Events After Hospitalization—Are We Missing the Mark? | Clinical Pharmacy and Pharmacology | JAMA Internal Medicine | JAMA Network](#), on this situation in view of a study that asked if a pharmacist-led intervention could reduce the harm. In that study it was found that 28% of discharged elderly patients experienced an adverse event within 45 days, the most prevalent of which involved opioids. Interestingly, despite a concerted intervention, there was not a reduction in adverse events. The commentary authors propose more careful prescribing by hospital clinicians, especially when it comes to opioids. They also suggested more involvement of patients and their caregivers in making decisions about medication prescribing. The message here is that patients must insist on being part of prescription decisions when approaching hospital discharge. The things to look out for are clear indications (rationale) prescribing, potential for adverse drug interactions, and appropriate dosage for the specific patient.

Alcohol Withdrawal During Hospitalization

Alcohol dependence is common in our society and it may be exacerbated during times of social isolation such as a pandemic. Using a standard scale to assess alcohol dependence, a group of investigators studied the incidence of alcohol

withdrawal (AW) in a hospital system during three periods – pre-COVID, early in the COVID epidemic, and once stay-at-home orders were issued. [Alcohol Withdrawal Rates in Hospitalized Patients During the COVID-19 Pandemic - PubMed \(nih.gov\)](#). They found that rates of AW increased stepwise during these three periods. That outcome is not a surprise. Herein, I use it to point out that AW symptoms are not uncommon in hospitalized patients. This means that there is a missed opportunity to help the patient become less alcohol dependent if they are not supported by a post-discharge system that helps alleviate alcohol dependence. One estimate is that about ½ million hospitalized patients suffer from AW, and there are effective treatments for this potentially life threatening problem ([Nursing Care 2020](#)).

Liberal Blood Transfusion May be Unwarranted

A large team of investigators conducted a trial in 35 hospitals involving 668 patients (median age 77 years) in France and Spain in which patients with anemia and a recent heart attack were randomized into two groups. [Effect of a Restrictive vs Liberal Blood Transfusion Strategy on Major Cardiovascular Events Among Patients With Acute Myocardial Infarction and Anemia: The REALITY Randomized Clinical Trial | Acute Coronary Syndromes | JAMA | JAMA Network](#). In one group (liberal), blood transfusion was initiated at or below a hemoglobin level of 10 g/dL and in the other group (restrictive), it was not initiated until the level was at or below 8 g/dL. This was a non-inferiority study, asking if the restrictive transfusion protocol was inferior to the

liberal transfusion protocol. The outcome measured was a composite of all-cause death, stroke, another heart attack, and need for revascularization.

The investigators found that the restrictive transfusion protocol was not inferior to the liberal one, indeed, it appeared that the restrictive protocol was better. Eleven percent of patients in the restrictive group suffered an adverse outcome whereas, 14% of those in the liberal group experienced an adverse outcome. Thus, in this study, liberal transfusion was about 20% more likely to cause an adverse outcome than restricted transfusion. The lesson for patients and their advocates is to ask questions if the clinician appears to be too anxious to transfuse someone.

Smoking and Surgical Patients

A small team of investigators noted that surgery may be a ‘teachable moment’ when the surgical patient is a smoker and therefore, may be more susceptible to changing his behavior. [Prevalence and Trends in Smoking Among Surgical Patients in Michigan, 2012-2019 | Lifestyle Behaviors | JAMA Network Open | JAMA Network](#). The investigators inspected records of almost 330,000 patients treated from 2012 to 2019 in 70 Michigan hospitals. They found that the prevalence of smoking was 24% in this group, and that the prevalence decreased each year, reaching a level of only 22% in 2019. Medicaid patients and those with no insurance were more likely to be smokers than those with commercial insurance or on Medicare.

The investigators note that the prevalence of smoking among surgical patients is well above the prevalence of smoking in the general adult population (23% vs 19%) in Michigan. The investigators cited studies showing that surgeons are reluctant to engage patients in cessation efforts due to time constraints, resource limitations, or thinking it would be futile.

Caesarian Deliveries and Hospital Profits

It is an open secret that profits often motivate the behavior of hospitals and physicians. A dedicated team of investigators examined the

discharge data on a nationally representative sample of women at low risk of needing a Caesarian delivery between 2010 and 2014, encompassing more than 13 million deliveries, of which 2.2 million involved a C-section. [Evaluation of Hospital Cesarean Delivery–Related Profits and Rates in the United States | Pregnancy | JAMA Network Open | JAMA Network](#). They also found the profits (not cost to patients) produced for each Caesarian delivery in the hospitals, dividing these into four median levels (quartiles). The profits varied from \$5,000 in the lowest quartile to \$26,000 in the highest quartile.

The probability of a low-risk woman having a C-section in a high-profit hospital was about 8% higher than in a low-profit hospital. The investigators opine that it is not clear what may motivate physicians to perform more C-sections, but certainly if their income is directly tied to payments, that is a likely factor. C-sections are known to be overused in the U.S. compared to other developed countries. Efforts to reduce the high rate have not met with much success. The Healthy People 2020 initiative has called for a reduction to 24% in the US for women at low risk. This would be about a 10% reduction from the current rate.

Breast Cancer Centers May Recommend Too Much Screening

Three MDs discuss the fact that many ‘Breast Cancer Centers’ do not follow breast cancer screening recommendations from the USPSTF (gold standard). [Recommendations From Breast Cancer Centers for Frequent Screening Mammography in Younger Women May Do More Harm Than Good | Breast Cancer | JAMA Internal Medicine | JAMA Network](#). For women in the 40-49 year range the USPSTF recommends shared decision making between clinician and patient before screening. Biennial screening is recommended for women 50-74 years old at normal risk of breast cancer. The reason for the latter is that annual screening produces many more false positives without any significant gain in mortality reduction. Many of the ‘Breast Cancer Centers’ recommend a start for

annual screening at 40 years of age, even for women at average risk of breast cancer.

In my opinion, women with average risk of breast cancer should do two things. First, determine whether you *are* at average risk for breast cancer [What Are the Risk Factors for Breast Cancer? | CDC](#) and then, second, discuss how often you need to be screened for breast cancer in light of trusted guidelines, such as those from the USPSTF. Tell your clinician that you are aware that harm is more likely from too much screening.

Precision Dosing

Precision dosing entails finding the dose that elicits maximum health benefits while minimizing the risk of harmful outcomes. Precision doses for many medications will vary from patient to patient. I know of several people who have been prescribed higher doses of blood pressure medicine, resulting in too low blood pressure (diastolic less than 60 mmHg) or in one case, near fainting at work due to starting the patient's medication at too high of a dose. Two experts wrote [Precision Dosing: A Clinical and Public Health Imperative | Clinical Pharmacy and Pharmacology | JAMA | JAMA Network](#), their viewpoint about barriers to implementing precision dosing and how to overcome some of those barriers. This requires the ability to measure desired effects and the incidence of harmful outcomes. Obviously, this is not easy to implement.

Studies in subpopulations will be essential and limitations in liver and kidney function must be discerned in terms of metabolism of the drug. In some cases, the genotype of the patient will have a huge bearing on optimizing the dose. Experts must identify drugs that are suitable for precision-dosing studies because resources will not permit doing these on all approved drugs.

In my opinion, the experts did not emphasize the role of patients in improving precision dosing. Patients may report the health benefits of a drug to their doctor and if serious adverse effects happen, then these should be reported to the [FDA Adverse Event Reporting System \(FAERS\) | FDA](#) and to your clinician. If you have limited liver or kidney

function, ask your prescribing clinician how these may impact your risk/benefit profile. If you have limited heart function, ask about effects on that vital organ. When starting a new medication, ask if you were prescribed the lowest effective dose and whether your new medication could cause harm because of interactions with other drugs you are taking. Of course, you must ask if it is off label for you and whether it has a 'black box warning.'

CNS-Polypharmacy in People with Dementia

I have had experience in my family with the acute effects of CNS-active drugs given to my father, who had dementia. He lived for a few weeks in a skilled nursing facility. These drugs clearly had an adverse effect on him but were not stopped until the family demanded that they be stopped. A team of investigators [Prevalence of Central Nervous System-Active Polypharmacy Among Older Adults With Dementia in the US - PubMed \(nih.gov\)](#) asked how often community-dwelling older adults with dementia are prescribed three or more CNS-active drugs. They examined 1,160,000 Medicare claims records of community dwelling adults with dementia from 2017 and 2018, finding that 14% had CNS-active polypharmacy. Each medication had to be prescribed for more than 30 days. Antipsychotics, antidepressants, antiepileptics, hypnotics, and opioids were included. The median age of those having polypharmacy was 79 years.

The authors note that they do not have information about the indications (rationale) for prescribing such medications, so they cannot judge the value of the polypharmacy. In my opinion, if you are looking after an older adult, with or without dementia, you must ask whether CNS-active medications may be doing more harm than good, especially if 3 or more are prescribed. Ask for the indication when a new medication is prescribed.

Diagnosing and Treating Hair Loss

A couple of MDs wrote a 'clinical update' on [Diagnosis and Treatment of Nonscarring Hair Loss in Primary Care in 2021 - PubMed \(nih.gov\)](#). Scarring hair loss entails permanent loss of hair follicles. If the

hair loss is deemed non-scarring, then it is classified as patterned, diffuse, or focal. The writers provide clear diagrams showing how these are distinguished. One type of patterned loss is androgenic alopecia. This responds to medications and low-level light. A type of diffuse hair loss, telogen effluvium, typically happens a few months after bodily stress – thyroid disease, pregnancy, vitamin deficiency, anemia, etc. The stressing event may be diagnosed and corrected, but full return of hair is slow. A focal type of hair loss, alopecia areata, is typically caused by an autoimmune condition. Regrowth is sometimes spontaneous. If that does not happen, then there are a variety of medication treatments.

COVID ARTICLES & GENERAL LINKS

Meta analysis shows that convalescent plasma does not help prevent COVID deaths: [COVID meta-analysis: No benefit from convalescent plasma | CIDRAP \(umn.edu\)](#)

Pfizer vaccine reduced COVID cases 94% in Israel: [Covid-19: Pfizer BioNTech vaccine reduced cases by 94% in Israel, shows peer reviewed study | The BMJ](#)

Evolving virus posing serious threats to us: <https://www.washingtonpost.com/health/2021/03/07/scientists-underestimated-coronavirus-are-racing-keep-up-with>

One size fits all with vaccines is unwise: [Surgeon warns of 'one-size-fits-all' approach to COVID vaccine \(msn.com\)](#)

How drug companies exploit the 'system' to sell unneeded drugs (43 minutes well spent): ["How Drug Companies Affect Medical Knowledge," Adriane Fugh-Berman MD - YouTube](#)

What Americans do not know about their medications: [Levaquin and Cipro Side Effects and the Drug Label Problem - The Atlantic](#)

Blog of David Lind from Iowa for reform of state medical boards: <https://hhri.net/reforming-state-medical-boards-are-essential/>

JAMA walks back its comment that no physician is racist: [JAMA apologizes and deletes tweet that questioned racism in medicine - MarketWatch](#)

Cleveland Clinic, rated No. 2 in the world, is not thought well of by patient advocates: [Cleveland Clinic Ranked No. 2 Hospital in the World by Newsweek – Cleveland Clinic Newsroom](#)

It received an 'A' rating from Leapfrog: [Cleveland Clinic Foundation - OH - Hospital Safety Grade](#)

New website by Lori Nerbonne for New England patients: [NE Patient Voices - Home](#)

NYT investigation finds nursing home much worse than reported: [How U.S. Ratings of Nursing Homes Mislead the Public - The New York Times \(nytimes.com\)](#)

[Nursing homes are gaming CMS star ratings system, New York Times probe finds \(beckershospitalreview.com\)](#)

Large hospitals not complying with CMS transparency rules: [Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule | Health Affairs](#)

New law: [Federal Rules Mandating Open Notes](#)

Health Watch Newsletter (many pertinent topics): [20210401-HWUSA-Newsletter.pdf \(healthwatchusa.org\)](#)

Patient Information

- *[Screening for Hearing Loss in Older Adults | Geriatrics | JAMA | JAMA Network](#)
- *[Screening for Lung Cancer | Cancer Screening, Prevention, Control | JAMA | JAMA Network](#)
- *[Hair loss - Diagnosis and treatment - Mayo Clinic](#)



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Answer to question: FALSE. Much improvement is needed. [State Medical Board Recommendations for Stronger Approaches to Sexual Misconduct by Physicians | Ethics | JAMA | JAMA Network](#)