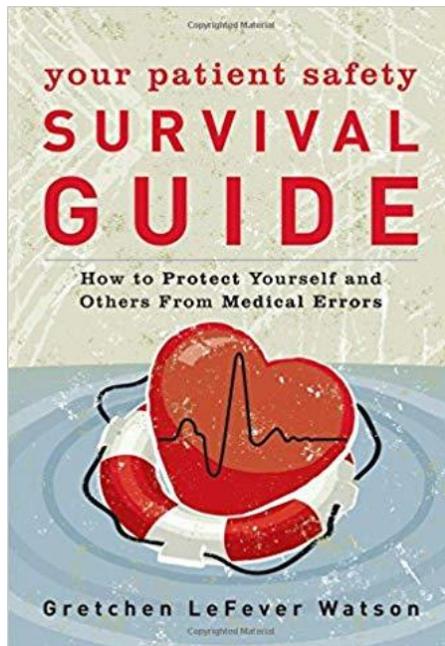


Question: What portion of American women have experienced sexual, physical or stalking violence?
 a) 5% b) 10% c) 15% d) 20% e) 25% f) 30%

Book Review: Your Patient Survival Guide – How to Protect Yourself and Others from Medical Errors
By: Gretchen LeFever Watson

Dr. Watson is a PhD clinical psychologist who has been stationed at the front lines of hospital care and has championed specific changes needed for safer healthcare. For example, she was part of the effort to stop the over-diagnosis of ADHD (attention deficit hyperactivity disorder) in children. In this book, she attempts to do something unique by lacing together a scolding of the healthcare system because of its harmful mistakes and coaching patients and practitioners on how to reduce the risk of harm.

She focuses on three major types of harm (her so-called trifecta) as follows: healthcare-acquired infections (HAI), harm from medication mistakes, and harms associated with surgery or invasive procedures. As I read further into her descriptions of harm, I was thinking that she had forgotten communication errors; however, for many of the case studies she describes, she points out where communication errors were part of the pathway through the Swiss-cheese model she used to illustrate causation of patient harm. That model postulates that harm occurs when a number of errors align to permit the pathway to harm to pass readily



through a series of holes, as one might suppose when viewing Swiss cheese.

She begins with a succinct history of the patient safety movement, which seems peppered with failed initiatives and only a few successes. The challenges of changing to a safety culture in the face of ingrained bad habits remains daunting. She devotes a section to the difficulty of engaging patients in their care, noting that they fail to assert their rights. Most hospital employees are fearful of speaking up when serious safety problems persist.

She tackles the issues associated with HAIs first, noting simple solutions such as hand washing are a challenge to implement. I was delighted when she included the story of Dr. Ignaz Semmelweis, who in the middle 1800s discovered the protection afforded to women during childbirth by doctors washing their hands with chlorinated lime. Alas, the good doctor's findings were ridiculed and he was forced into an insane asylum. Even today, the call to better handwashing is a difficult sell.

Dr. Watson tackles mistakes during surgery, focusing on never events, such as surgery on the wrong patient or surgery on the wrong body part. She advocates for a checklist, including a time-out to ensure all is proper for surgery to proceed. The patient has a critical role in ensuring parts of the checklist. She ends each chapter with summary information and an action plan for patients and providers – quite neatly done.

Next, the author presents the risks associated with medication harms. She notes that there is a

concept called the “five rights” of medication administration. The right patient, drug, dose, route, and time. I might have backed this up a bit to include the right prescription in the first place before any administration commences. She treats the issues associated with opioids separately.

Her final chapters espouse the idea of improvements accomplished one community at a time. While this may be one approach, there are others that that would be more global and involve institutions at the fringe of the medical industry, such as state medical boards. She finally enters the dark space of what should happen when a patient is harmed. She follows the common paradigm of treating the apparent “perpetrator” of the harm as “second victim.” Personally, I don’t like this label. The real “second victim” is the family of the person seriously harmed. This may lead to a lifetime burden of care or a lifetime of grief over the loss of a loved one. Dr. Watson rightly acknowledges that resources must be available to help caregivers who make harmful mistakes.

I admire Dr. Watson’s pleasant style of writing, and her systematic approach to solving some important problems in patient safety. Perhaps, I have been too critical of what she has not tackled. After all, it is a huge problem that will not yield easily to simple solutions, even when patients and providers are attempting to co-create safer care. 4 ½ stars. About \$33

Use Fewer Medications - Deprescribing

Last month’s newsletter contained a book review on how medicines that reach you may not be as safe as you believe because of the poorly regulated industries in China where they originate. Another danger lurks from the way medications are prescribed in the U.S. That is the over-prescribing that may come to patients with multiple chronic conditions. The way to correct over-prescribed medications is to go through medication reconciliation, or as the process is now more commonly called “deprescribing.” Several articles regarding the importance of that process caught my eye this past month.

According to an article in *JAMA Internal Medicine*, the landscape of deprescribing looks like

[this](#). Use of inappropriate medications in older adults is common and is associated with polypharmacy (use of 5 or more medications). Approximately half of folks 65 or older use 5 or more medications. This can lead to harmful drug interactions, hospitalizations, diminished quality of life, and even death. It seems that physicians believe that patients are not much interested in deprescribing.

A team of 6 experts, interestingly all women, investigated whether patients are averse to deprescribing of medications. They asked almost 1900 patients two questions as follows: “If my doctor said it was possible, I would be willing to stop one or more of my regular medications,” and “I would like to reduce the number of medications I am taking.” The researchers found that 92 % answered in the affirmative to the first question and 67 % to the second question. The authors conclude that older Americans are willing to consider reducing the number of their medications through physician recommended deprescribing.

Given this observation, one might ask about the involvement of pharmacists in eliciting deprescribing. In a study involving almost 500 community dwelling older adults in Quebec, Canada, [investigators](#) asked pharmacists to send a brochure on deprescribing to patients and also one on evidence-based guidelines for deprescribing to their physician; this was the intervention group. The control group did not receive such information. Six months later 43 % of the intervention group no longer took inappropriate medications, whereas only 12 % of the control group had discontinued inappropriate medications. The authors caution that their findings need replication in other settings before any general conclusions are reached.

A commentary on the Canadian study noted the [inertia to change](#) in medicine. The comments emphasized the role of pharmacists in identifying inappropriate medications, and the patient’s role in being able to trust the quality of the deprescribing. It seems to me that the Canadian study brought home the idea that deprescribing is a partnership between patient, clinician, and pharmacist. If you are a patient taking 5 or more medications, ask for a review by your clinician and pharmacist in reducing

their number. Do not wait for your doctor or pharmacist to initiate this process. One more note: prescribing or deprescribing should be one medication at a time. That is the only way to clearly understand the effect of a newly prescribed drug or one that has been newly deprescribed. Too many changes at once lead to confusion.

Fixing Our Edsel – Healthcare

For those of you too young to know, Edsel cars were produced by Ford Motor Company in the late 1950s for a few years. They featured a unique, vertical grill, a large engine and luxurious appointments. The early production models were rife with problems and the marketing schemes were bizarre. They lasted only a few years because no one wanted one. Even though the U.S. healthcare non-system performs for many Americans like an Edsel, it is not going to be easy to replace it. None-the-less, a well-known economist, Victor Fuchs, wrote his [opinion](#) about how to make U.S. health care more affordable and equitable.



He begins by pointing out that our health care costs, about \$10,000 per person per year on average and is 50% more expensive than in any other country. The U.S. spends \$3,300,000,000,000 (\$3.3 trillion) each year on healthcare. A primary cause is the arrival of expensive technology, to include drugs and devices. A second cause is employer based insurance that favors those with higher wages over those with low wages. We also have large marketing and administrative costs compared to other developed countries.

The fixes he proposes are to replace employer-based insurance with a tax-based system that offers universal eligibility. He proposes changes

to the organization and delivery of health care. Limit the role of government. Offer annual enrollment in a choice of health plans, with the proviso that one can use personal funds to purchase additional coverage. Foster competition among health plans and physicians. Work away from fee-for-service payments. He notes that it will take an unusual time, perhaps a crisis of some sort, to bring politicians together to make some of this happen. He does not anticipate this situation any time soon.

Patient Autonomy and Physicians

A couple of [experts wrote](#) their opinion in the *JAMA* on how physicians must adjust to the growing autonomy of patients when it comes to making decisions about their healthcare. The old paternalistic models of medical decision-making are quickly disappearing. Given internet and social media sources of information, patients may come to their doctors with a good idea of what their illness may be. They may have already ordered genetic tests or limited clinical laboratory testing to understand what's going on in their body. Physicians must learn to deal with such information as they elicit patient preferences during shared-decision making to decide together what is the best way forward. Physicians will naturally have a much greater depth of technical knowledge than patients, and they will control access to most tests needed to make or confirm a diagnosis.

I was surprised the authors did not address decision aids for patients. The authors seemed to believe that physicians have absolute knowledge when it comes to making a diagnosis and treatment plan. There is often great uncertainty in diagnosis and treatment, and this uncertainty needs to be a part of shared-decision making. Furthermore, if the physician has not made a concerted effort to stay on top of new information, then it may be impossible to reach an optimal decision on how to proceed. I know a person that recently had a painful ear infection. She went from doctor to doctor getting an array of treatment options that did not work. Finally, she found a capable ear doctor who said none of what she had been told was right. She had an inflammation that was quickly healed with topical applications of a steroid and antibiotics.

Minimally Invasive Surgery for Cervical Cancer

You may have seen the NBC News piece on the association of harms with use of robotic surgery on December 20, 2018 ([robotic surgery NBC](#)). A new editorial in *The New England Journal of Medicine* [critically analyzes](#) recent data on the use of minimally invasive procedures, including robotic surgery, compared to open surgery for early stage cervical cancer. Two lines of evidence suggest that open surgery leads to better outcomes than laparoscopic or robot-assisted surgery. In fact, one trial was stopped early because of the obvious better mortality outcomes when open surgery was used. This seems to contradict results from meta-analysis showing that the two approaches yield similar disease-free survival.

Confounding a woman's decision is the higher possibility of immediate complications from open surgery vs. the less invasive types of surgery. Open surgery increases the risk of blood loss during surgery, leads to longer hospital stays, and more perioperative complications. If I were facing such surgery, I'd get at least 2 expert opinions and consider what I value most. Is a higher probability of 5-year survival worth the near-term discomfort of open surgery?

Patient Pages

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Answer to question: e) 25%, source: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2707820>

Medicaid Expansion and Death from End-Stage Renal Disease (ESRD)

As many of my readers know, Texas has refused to expand Medicaid so that Texans living just above the poverty level can have insurance to support their healthcare needs. One need of many of us as we age will be dialysis or a kidney transplant to remain alive in the face of ESRD. A [commentary](#) on a new [study](#) examines the results of that research.

Since kidneys are not often available for transplantation, 97% of Americans with ESRD must depend on dialysis to stay alive. There are approximately 125,000 new people each year needing dialysis. A team of investigators looked at records on people aged 19 to 64 who went on dialysis from 2011 to 2017. They compared findings in Medicaid-expansion states vs. non-expansion states. In the former, insurance coverage increased 11%, whereas in the latter, insurance coverage dropped 1%. The relative reduction in mortality associated with Medicaid expansion was 8.5%.

The editorialists point out several important limitations of studies such as this, but note that other studies have shown improved mortality or outcomes in the face of other healthcare needs if Medicaid



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coverage is expanded. These include reductions in maternal mortality and better outcomes following cardiac surgery. If you live in a state where Medicaid expansion has been denied, then consider writing your governor, legislative leaders and your specific senator and representative, asking that Medicaid expansion be reconsidered because it saves many lives.