



QA

WITH DR. MEDLAW

As a urologist I am very sensitive to my patients' need for privacy. However, I was really surprised when a new patient got very nasty with my receptionist because he was asked to sign in on a sheet at the front desk. He was carrying on about how this is a HIPAA violation because other patients signing in can see his name. I thought that a sign-in sheet is actually acceptable under HIPAA.

It is, as is announcing a patient's name in the waiting room to tell them that they are the next to see you or saying their name in the hearing of other patients or visitors. Under HIPAA these revelations of PHI are considered incidental to medical care.

However, you should be doing your part to minimize that revelation. Start with the fact that PHI is an identifier coupled to a medical fact. All that a sign-in sheet alone therefore reveals is that someone is your patient so make sure to not expand it beyond that—why the patient is there should never be included. Using a peel-off type of sign-in sheet is also a good idea—while not a HIPAA requirement, it does make patients feel more protected and avoids a situation like this.

Similarly, when discussing a patient where others might overhear, keep your voice low, and when calling a patient in from the waiting room do not mention the reason that they are there. For example, your MA saying "Mr. Joe Smith, come with me please" is acceptable but "J.S., we are ready for your cystoscopy" is not because the issue is not the completeness of the name but the association of that identifier to the specific personal medical fact.

Having these as policies in your employee manual will stand you in good stead if you ever have to defend against a complaint from a troublesome patient.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.



"I use so much alcohol-based hand sanitizer, my hands had to join a 12-step program!"



Exploring Contraception Use Among Women With Rheumatic Diseases



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Contraceptive use among women of reproductive age with rheumatic diseases appears to be low. Efforts are needed to improve contraceptive care and access to reproductive healthcare for these women.

Published research suggests that more than two-thirds of women who are of reproductive age in the United States actively use contraception, but few studies have explored use of these treatments among young women with rheumatic diseases. Despite the potential benefits of contraception, results of several surveys of young women with these diseases have demonstrated that few actually received contraceptive counseling, used any contraception, and rarely used highly effective contraceptive methods like

subdermal implants and intrauterine devices. Why this occurs remains unclear.

To address this research gap, Mehret Birru Talabi, MD, PhD, and colleagues conducted a study, published in *Arthritis Care & Research*, that examined the prevalence and predictors of contraception use among reproductive-aged women with a variety of rheumatic diseases. The investigators assessed 2,455 women who had one of 21 possible rheumatic disease diagnoses and at least two outpatient rheumatology visits. Using logistic regression analyses, they evaluated adjusted associations between the use of prescription contraception, use of potentially fetotoxic medications, and visits with rheumatologists, primary care providers (PCPs), and gynecologists.

Analyzing the Findings

Results of the analysis showed that only about 32% of women with rheumatic diseases received any prescription contraception, and just 8% used highly effective prescription methods like intrauterine devices, implants, and surgical sterilization. "Our analysis suggests that some women with rheumatic diseases may be at risk for unintended pregnancy," says Dr. Birru Talabi. "This is particularly concerning among this patient population, because many of these women may be at risk for pregnancy complications."

More than 70% of women in the study took one or more types of potentially fetotoxic medications, which can increase risks for adverse perinatal outcomes. Fetotoxic medication use was not associated with overall use of prescription contraception, but it was linked to a greater likelihood of using highly effective contraceptive methods. "Many women were exposed to potentially fetotoxic medications, but overall, just a minority used prescription contraception," notes Dr. Birru Talabi.

The study also revealed that, overall, women who saw gynecologists or PCPs were more likely to use prescription contraception (Table). Women

who saw gynecologists were also more likely to use highly effective contraceptive methods rather than moderately effective contraception. However, most women had no documentation of a gynecologist or PCP visit over the 2-year study period. In addition, women who had more than two visits to a rheumatologist were no more likely to use prescription contraception than those who had fewer visits in fully adjusted models.

Examining the Implications

Findings of the study suggest an urgent and unmet need to enhance patient care, and family planning counseling appears to be warranted for some reproductive-age women with rheumatic diseases. "Gynecologists and PCPs are important resources for delivering contraceptive care, but rheumatologists can also play a role," Dr. Birru Talabi says. "Rheumatologists should recognize that practice patterns have changed, with many patients no longer seeing PCPs and gynecologists for annual visits. Therefore, some of their highest-risk patients may lack access to a reproductive healthcare provider who can help manage their contraception or other reproductive health needs. The fact that these women may have gaps in contraception care is an important public health message."

Rheumatologists may help to fill important gaps in care by educating patients on the associations between disease activity, pregnancy, and fetal risks associated with certain rheumatic drugs, according to Dr. Birru Talabi. "In addition, rheumatologists can potentially prescribe emergency contraception and/or partner with other providers to ensure safe contraception prescribing when appropriate," she says. "Rheumatologists can also help bridge gaps in access to reproductive healthcare by referring women with rheumatic diseases to primary care and/or gynecology. It is important for PCPs and gynecologists to also actively screen patients for their interest in avoiding or experiencing a pregnancy and to work with rheumatologists to help patients meet their reproductive goals safely." ■

Third Leading Cause of Death Revisited



Written by
Skeptical Scalpel

Ever since the publication of the infamous 2016 *BMJ* opinion piece by Makary claiming medical error should be considered the third leading cause of death in the US, the debate on the true incidence of deaths caused by medical error has been raging. Many, including me, felt the Makary estimate of 251,000 deaths per year from medical error was grossly inflated. For example, Makary extrapolated the number of deaths from three outdated studies with a total of just 35 deaths, and medical error was not well-defined.

A new paper in *BMJ Open Access* by investigators from the UK looked at 70 studies involving 337,025 patients mostly treated in general hospitals. Of that total, 47,148 suffered harm with 25,977 (55%) of harms judged as preventable.

The authors concluded "The pooled prevalence for preventable patient harm was 6% (95% confidence interval 5% to 7%). A pooled proportion of 12% (9% to 15%) of preventable patient harm was severe or led to death." I'll do the math; 12% of 6% is 0.72% or just over 2400 preventable severe harms and deaths.

A recent literature review on the website *Healthy Debate* Canada cited three papers estimating incidence of preventable deaths due to medical error ranged from less than 1% to 5.2% and said "This would correspond to 15,000-35,000 deaths per year in the US, an order of magnitude lower than the *BMJ* estimate."

Even one preventable death is too many. However, inflated figures like 251,000 deaths or even 440,000, as a 2013 paper claimed, undermine public confidence in medical care.

Some examples. The Canadian authors said calling medical error "the third leading cause of death" in the US enabled supporters of the NRA to say doctors are more harmful than guns. Naturopaths and alternative news sites warned about the dangers of our health system.

From *Healthy Debate*: "In-hospital deaths from medical error are a small subset of all medical errors, and non-fatal errors cause considerable harm to patients. Considering that most of health care occurs in the ambulatory setting, there is an even larger potential for error to cause harm outside of hospitals." Focusing too much on in-hospital deaths from error may direct attention away from other areas of quality improvement.

Medical error is not the third leading cause of death in the US. Will people stop saying it is? I doubt it. ■

Osteoporosis Trends & Disparities



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Data indicate that the declining trend of hip fracture among Americans plateaued in 2012 before increasing through present day. "Since hip fractures are the most common result of osteoporosis, this shift indicates that the trend of the disease might have changed," explains Qing Wu, MD, ScD. While health disparities can be observed across numerous diseases, studies examining osteoporosis trends among US adults by different socioeconomic status are limited, and the prevalence of self-reported osteoporosis in the US is rarely reported. "In order to understand the bone health status of Americans, it is essential to examine the trends and disparities in osteoporosis," notes Dr. Wu.

For a study published in the *Journal of Clinical Medicine*, Dr. Wu and colleagues used NHANES data to evaluate the bone health of Americans. "We examined the age-adjusted prevalence of self-reported and measured osteoporosis in recent years," he adds. "In addition, the prevalence was compared between gender, race/ethnicity, and socioeconomic status (SES, including educational attainment and family income)."

Among more than 8,000 participants, the prevalence of self-reported osteoporosis was significantly higher than that of measured osteoporosis in 2007-2014 for women, as well as in 2007-2010 for men. "Participants with higher educational attainment had an increased prevalence of measured osteoporosis during recent years," Dr. Wu says. "Among all SES groups, participants with a low family income had the highest prevalence of measured osteoporosis, and a significant increase was observed during the study period, from 49.3 per 1,000 population to 71.8 per 1,000 population."

With the study results suggesting that women have a better understanding of osteoporosis than men, Dr. Wu suggests that increasing awareness of the disease among men could be a priority for future prevention campaigns. "Recommendations on increasing physical activity and reducing sedentary time may help to prevent osteoporosis among people with high educational attainment," he adds. "Physicians might need to pay more attention to the bone health of individuals with disadvantaged SES, such as those with low family income. Addressing disparities in osteoporosis will help to improve the bone health of Americans." ■

Table Identifying Key Predictors

The table below depicts predictors of any documented prescription contraception versus no documented contraception (n=2,455),* according to data from a published study.

	Unadjusted Odds Ratio	Adjusted Odds Ratio
FDA medication pregnancy risk category		
Class D,X	1.04	1.04
Class A,B,C	Reference	Reference
Outpatient clinic visits		
Rheumatology visits >2	1.22	1.22
- Visits=2	Reference	Reference
Primary care provider visit ≥1	1.75	1.43
- Visits<1	Reference	Reference
Gynecologist visit ≥1	3.53	3.35
- Visits<1	Reference	Reference

* Reference category for all models is no documented contraception. Adjusted models include all covariates in addition to age, race, and marital status.

Abbreviations: D,X=FDA category of high risk; A,B,C=FDA category of low risk or unknown risk.

Source: Adapted from: Birru Talabi M, et al. *Arthritis Care Res (Hoboken)*. 2019;71(8):1132-1140

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