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Just about everyone who works at our family practice office (PAs, an RN, and clerical staff) is also a patient there. Needless to say, many of them are accessing their own records. I have talked to my partners about this because I am really concerned that we would be hit hard about this in a HIPAA investigation, but they said that it is fine because people are only looking at their own records, which they have a right to do. Are they correct, or am I?

You are.

A patient has the right to see their records but could not just go to the receptionist's desk and start downloading them. The same applies if they happen to work at the practice. There are proper procedures to follow.

The real issue is that this conduct is a red flag for HIPAA laxity at your practice if you are ever investigated, even for another reason, because it shows that you are treating records as an open access matter to all staff, including non-medical staff, which is an invitation to improper use. When records access is unregulated, it is frankly inevitable that there will eventually be privacy violations, such as looking up the records of someone the staff member has a personal question about.

When a staff member wants their results, have them submit a request just like any other patient would or simply ask their treating practitioner to check for them. Include this as a set policy in your office's employee regulations that can be proffered to the OCR as proof that you deal with this properly if you are investigated or used as evidence in a lawsuit for a privacy breach under state confidentiality law.

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



Postoperative Infection: A Look at Risks for Long-Term Infection & Mortality



Written by William J. O'Brien, MS, Statistician, Surgical Service and Center for Healthcare Organization & Implementation Research, VA Boston Healthcare System

Patients who have an infection within 30 days of surgery appear to be at higher risks of subsequent infections and mortality for up to 1 year, according to a study.

Throughout the United States, significant resources are being used to prevent postoperative infections due to their potentially serious consequences. "Much attention has been given to the identification, prevention, and management of postoperative infections, typically within 30 days of surgery or up to 90 days for surgical implants," explains William J. O'Brien, MS. "In the short term, these infections can be devastating for patients in terms of pain, need for reoperation and rehospitalization, and exposure to long-term antibiotics. However, it remains unclear if patients exposed to infection after surgery have higher rates of subsequent infections and mortality within 1 year."

For a study published in *JAMA Surgery*, O'Brien collaborated with Kalpana Gupta, MD, and Kamal M.E. Itani, MD, to determine if exposure to 30-day postoperative infections was associated with a higher incidence of infection and mortality up to 1 year after surgery. Using data from the Veterans Affairs (VA) national database, the study included more than 650,000 veterans who underwent a broad range of major surgery types during

an 8-year period. The exposure group included VA patients who had any 30-day postoperative infection while the control group consisted of VA patients who had no 30-day infection.

Study Highlights

According to investigators, 3.6% of all participants in the study had a 30-day infection, 6.6% had a long-term infection, and 3.8% died during follow-up. Overall, the incidence of infection during postoperative days 31 to 365 was 6.7%. The most frequent 30-day infections were surgical site infections, urinary tract infections, pneumonia, and bloodstream infections. The most frequent types of infections on postoperative days 31 to 365 were urinary tract infections, skin and soft tissue infections, bloodstream infections, pneumonia, or a combination of two or three types simultaneously (Figure).

"Our key findings were that patients with a 30-day postoperative infection were at nearly twice the risk of mortality and had more than three times the risk of subsequent infection when compared with patients without such an infection," says O'Brien. When compared with patients who had no postoperative infections, those with these infections tended to be older and more frequent-

ly had an American Society of Anesthesiologists score greater than 2. The study also found that patients with any postoperative infection were more likely to have undergone emergent surgery and to have undergone surgery with a duration in the highest quartile when compared with patients who had no postoperative infections.

Findings of the study persisted after adjusting for baseline characteristics. Although few published studies have examined rates of long-term infection, results from the current study were comparable to those of previous work that sought to describe mortality risks.

Critical Implications

Efforts to prevent postoperative infections continue to be a high priority in clinical practice and across healthcare settings because of their significant impact on costs, patient outcomes, and resource utilization. The novel contribution of the study by O'Brien and colleagues is that the occurrence of a postoperative infection—regardless of patient characteristics and surgery factors—appears to be associated with a higher likelihood of having a subsequent infection and mortality up to 1 year after the initial surgery.

"Our study demonstrated that postoperative infections in the overall surgical population were relatively uncommon but associated with long-term harm to patients," O'Brien says. "Our study wasn't intended to directly influence surgical practice. Instead, our goal was to better understand the long-term risks of surgical infections. Future work in this area could help us appreciate the extent to which the long-term consequences described in our study are directly related to the postoperative infections." The study team added that the increased harm and cost of long-term infections should be included in cost-benefit calculations of infection prevention initiatives.

33 ||| CHARTS

Doctors and the Culture of Permission

Recently, Richard Smith, editor of *BMJ*, called out *NEJM* for failing to publish critical letters. His post in the *BMJ* blog network calls out *NEJM* as elitist. If electronic space is unlimited, he asks, why limit letters?

Good point. But why assume that conversation is controlled by *NEJM*? This is a great illustration of what I have come to call medicine's culture of permission.

As physicians, we've been raised to seek approval before approaching the microphone. For hundreds of years, you could only say something if someone gave you permission. It used to be that the only place we could share ideas was in a medical journal or from the podium of a national meeting. Our ideas were required to pass through someone's filter.

The angry scientists cited by Smith are of a generation when someone else decided if their ideas were worthy of discussion. They are a generation trained to contain what they think and believe. They are the medical generation of information isolation. Our culture of permission has bred a generation of obsequious followers.



When I think about my peers, I think about the remarkable mindshare that exists. Each is unique and brilliant in the way they think and see the world. Each sees disease and the human condition differently. They carry stories and experiences that can ease minds and save lives. But their brilliance and wisdom is stored away deep inside. They are human silos of unique experience and perspective.

But the way the world communicates and creates ideas is changing. The barrier to publish is effectively non-existent. The democratization of media has given every physician and scientist a platform to the world. But, somehow, we still believe that *NEJM* is running the show. The assumption here is that the only place for dialog and publication is within the boundaries of a paywall-controlled platform.

The problem here is not the antiquated ways of *NEJM*, but the dated, permission-based thinking of the medical public.

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OSA & Cardiovascular Events in Noncardiac Surgical Patients



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Prior research indicates an association between obstructive sleep apnea and unfavorable long-term cardiovascular outcomes in the general population. Studies assessing this association in perioperative patients have been mostly retrospective and from database reviews, leaving a need for high-quality and non-conflicting evidence. With the majority of perioperative patients presenting for surgery being largely unrecognized and untreated for OSA, if present, "The Postoperative Vascular Complications in Unrecognized OSA (POSA) group embarked on a study to determine the association between the diagnosis and severity of OSA based on preoperative home sleep apnea testing and 30-day postoperative cardiovascular outcomes among adults (aged ≥45) with at least one risk factor for postoperative cardiovascular events undergoing major noncardiac surgery in five countries," explains Edwin Seet, MBBS, MMed.

The study team observed a high rate or unrecognized OSA—approximately 11% of patients had severe OSA, 19% had moderate OSA, and 37% had mild OSA. "Severe OSA was associated with a higher rate of postoperative cardiovascular events (adjusted hazard ratio 2.23)," explains Dr. Seet. "It is, therefore, important to identify those patients with severe OSA and implement measures to reverse the hypoxia associated with OSA after surgery. Perioperative physicians should recognize that OSA (along with its concomitant disease processes) is a major perioperative risk factor."

Dr. Seet notes the logistic and financial constraints that prevent routine polysomnography sleep studies and even home sleep apnea tests preoperatively and suggests that patients, therefore, be routinely assessed with the STOP-Bang screening tool. "According to the results of the POSA study, patients with a STOP-Bang score of 5 or higher are at a higher risk of postoperative cardiovascular complications (1.7-fold)," he says. "These higher-risk patients should be monitored closely after surgery, and measures should be instituted to prevent severe oxygen desaturation."



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