

Top 10 Harms Patients Experience In Hospitals – Or Not



Written by **Skeptical Scalpel**

The website Health Exec: For Leaders of Provider Institutions recently published “Top 10 Harms Patient’s Experience in Hospitals.” It begins with this: “Medical mistakes are one of the leading causes of death in the US.”

The story is based on a white paper, “Top 10 Patient Harms in US Hospitals Based on EHR Data-2019,” from Pascal Metrics, an organization that uses the Global Trigger Tool to analyze data from EHRs in real time. If the Pascal Metrics list was generated from EHR data, its validity should already be suspect. But as you will see, no such data was used to create the list. Because of space considerations, I will only focus on the most egregious falsehoods.

Number 4 on the list is Abnormal Surgical Bleeding. From the article: “Abnormal surgical bleeding is unexpected blood loss that occurs following an invasive procedure. In a study that looked at patients who received a wide variety of specialty surgeries, 29.9% experienced bleeding complications, with associated costs ranging from \$2,805 for patients who experienced said complications from reproductive organ surgeries to \$17,279 for spinal surgeries.”

This study was published in 2011 and was based on 2006-2007 administrative data. It could hardly be relevant to 2019.

The paper involved several hundred thousand inpatients undergoing various types of major surgery. The incidence of bleeding complications was exaggerated in a clever way. Here’s how: for almost 104,000 cardiac operations, 47.4% of patients had some sort of “bleeding-related consequence,” which included blood transfusion. However, only 3.1% patients required re-operation. In other words, the authors considered a blood transfusion alone a significant event.

Number 6 is Organ Injury/Repair/Removal and mentions a Florida surgeon who, during a spine operation, removed a healthy kidney thinking it was a tumor. This case occurred in 2016 and is a series of one patient.

Number 9, Falls with Injury, gives no data about the incidence of falls with injury but rather says “in 2008, one health system had to pay \$2.5 million to a patient who fell in their ER.” How this series of one patient in 2008 relates to the top 10 harms in 2019 is a mystery.

The methodology said to have been used to formulate Pascal Metrics’ top 10 list of patient harms was “adverse event outcomes data generated from its cloud-based multitenant automated patient safety and quality improvement system between June 1, 2018 and May 30, 2019.” Yet, every one of the top 10 patient harms was actually derived from published research papers, records of a lawsuit, or the television program *Inside Edition*.

Health Exec for Leaders reported this garbage without questions. We can only assume that some hospital leaders read and believed it, which is shameful. ■



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Research has shown that obesity accelerates the development of certain cancers, including cancers of the digestive tract, gynecologic cancers, and multiple myeloma. I led a team of researchers from the School of Medicine at Case Western Reserve University and Case Comprehensive Cancer Center to examine if a shift of obesity-associated cancer (OAC) burden toward younger age groups has occurred in recent years.

A Look at the Numbers

For a study published in *JAMA Network Open*, we analyzed 17 years of cancer data from the National Cancer Institute’s nationally representa-

tive Surveillance Epidemiology and End Results (SEER) database. The study examined the shift in age at the time of diagnosis between 2000 and 2016, and identified the specific race/ethnicity and sex-specific strata most affected by OAC from more than 6 million cases.

In the group aged 20-49, the change in the number of OACs ranged from a 5.9% decrease in Caucasian women to a 94.6% increase in Hispanic women during the study period. While the results showed an increase in both OACs and non-OACs among individuals aged 50-64, the increase was greater for OACs than for non-OACs and ranged from a 25.3% increase in Caucasian women to a 197.8% increase in Hispanic men. The highest increase in the number of cases was observed among Hispanic men, at 2.6% annually for OACs, compared with 1.5% per year for non-OACs (Table). Among

individuals aged 65 or older, there was a decrease in the percentage of OAC cases across all race/ethnicity and sex-specific strata. In contrast, the percentage of non-OAC cases in this age group increased in Caucasian men and in women, regardless of their race/ethnicity.

The greatest increases in incident cases of OAC were observed in uterine cancer among Hispanic women (by over 200%), and in liver and thyroid cancers across all sex and race/ethnicity strata. Notably, the number of liver cases increased by more than 300% in the 50-64 age group among African-American women and Hispanic men.

Important Policy Implications

The importance of curbing the obesity epidemic cannot be overstated, not just to reduce cancer burden, but also to prevent premature morbidity and disability. Maintaining a healthy weight at all stages of life by promoting healthy dietary habits and physical activity is of highest priority. A shift of cancers to younger age groups implies that cancer is affecting people when they are at the height of their productivity, and the loss of potential years of life lost is substantial.

Given the financial toxicity associated with cancer, its treatment and recurrence, and end-of-life care, the impact on Medicare, Medicaid, and societal costs are significant. With more middle-aged individuals being diagnosed with cancer, people will increasingly transition to the Medicare program as cancer survivors potentially at younger ages and present with a greater burden of physical and mental comorbidities when compared with their cancer-free counterparts.

Our findings call for heightened vigilance by physicians to rule out cancer in younger individuals who present with symptoms suggestive of cancer. The old thinking of “too young for cancer” is not acceptable, given that younger people, as evidence suggests, are likely to present with more aggressive tumors and advanced-stage disease. For example, rectal bleeding in a young person should not be dismissed as a sign of hemorrhoids, but investigated to rule out colorectal cancer, especially in the presence of family history of colorectal cancer.

The results of our study highlight the importance of personalized cancer screening strategies, the parameters of which remain to be defined. While the specific criteria for personalized screening are being identified, symptoms and personal or family history of cancer should raise a red flag in the physician’s mind to rule out cancer, whether in the presence or absence of obesity. ■

Table Odds Ratios for OAC & Non-OAC by Group

Group	OR		OAC to Non-OAC Ratio of ORs
	OAC	Non-OAC	
MEN			
Age 20-49			
Non-Hispanic white	0.994	0.975	1.020
Non-Hispanic black	0.978	0.978	1.000
Hispanic	0.988	0.995	0.993
Age 50-64			
Non-Hispanic white	1.019	1.006	1.013
Non-Hispanic black	1.023	1.018	1.005
Hispanic	1.026	1.015	1.010
Age ≥ 65			
Non-Hispanic white	0.985	1.002	0.983
Non-Hispanic black	0.988	0.992	0.996
Hispanic	0.984	0.990	0.994
WOMEN			
Age 20-49			
Non-Hispanic white	0.988	0.972	1.016
Non-Hispanic black	0.978	0.964	1.015
Hispanic	0.990	0.971	1.019
Age 50-64			
Non-Hispanic white	1.015	1.011	1.004
Non-Hispanic black	1.023	1.018	1.005
Hispanic	1.017	1.015	1.002
Age ≥ 65			
Non-Hispanic white	0.994	1.005	0.989
Non-Hispanic black	0.993	1.007	0.986
Hispanic	0.993	1.012	0.981

Abbreviations: OAC, obesity-associated cancer; OR, odds ratio

Source: Koroukian SM, et al. *JAMA Netw Open*.



I have a patient to whom I was prescribing Prozac on a monthly basis. I last saw him 3 months ago, when I gave him a 1-month prescription as usual. After I did so, he became uncooperative and then said that he did not want another appointment, and I have not heard from him since. The pharmacy he listed with my office says that he has not filled a prescription since the last one that I gave him. He has not contacted my office about wanting a prescription. To close matters off, I will be sending him a formal termination letter. Do I have to include a prescription to avoid being charged with abandonment by this difficult patient?

No.

Let’s start with the fact that you are actually not terminating him, which does carry the duty of avoiding abandonment. You will actually be memorializing the fact that he terminated you. In that setting, there is no carryover obligation, because you are not the one ending the care.

However, even if you were the one doing the termination based on his non-compliance, you not only would not be obligated to provide a prescription, you should not do so.

To avoid a claim of abandonment in the termination setting, the doctor is responsible to tide the patient over the transition period to another practice. This includes being available for emergency care during that time and prescribing enough of current medications to cover the interval specified in the termination letter.

However, this patient has already stopped the drug for 2 months. If you prescribe for him now, you would actually be starting a new course of treatment. This would be the opposite of verifying his removal from your practice and could actually be held to vitiate the ending of the physician-patient relationship, because a patient who gets a new prescription could reasonably conclude that you were now treating them anew.

There is also a professional conduct issue to consider, since you would now be giving a psychoactive medication to someone you have had no clinical contact with for longer than your previous evaluation interval. This is different from a bridging prescription given to a terminated patient leaving active care.

Just send a letter verifying that, as per his statement that he no longer wishes to seek care with your office, that you are closing his file.

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



In Case You Missed It

Survival Worse for Breast Cancers Secondary to Childhood Cancer

Survivors of childhood and adolescent and young adult cancer who develop a secondary breast cancer have significantly decreased breast cancer-specific survival (BCSS), according to a study published in *Cancer Epidemiology, Biomarkers & Prevention*. Researchers obtained data from 107,751 female patients aged 12-50 diagnosed with primary breast cancer from 1988 to 2014 from the California Cancer Registry and 1,147 similarly aged patients with secondary breast cancer treated with radiotherapy for their primary tumor from age 12-39. The likelihood of being Hispanic or Black, being aged 35 to 45, having earlier-stage tumors, having higher-grade tumors, having no lymph node involvement, and being hormone receptor-negative were increased for the secondary breast cancer cohort. Worse BCSS was seen for large tumor size, lymph node involvement, and hormone receptor-negative status for all women. Women with secondary breast cancer had worse BCSS overall (hazard ratio, 1.98) and in all subgroups. The associations were strongest in Hispanics, Asian/Pacific Islanders, and younger women as well as those with earlier-stage, lymph node-negative, and hormone receptor-positive disease. “It will be important to prospectively evaluate how certain treatments, such as specific radiation fields or chemotherapeutic agents, can affect second primary breast cancer outcomes,” a co-author said in a statement.

Black-White Disparity in Lung Cancer Incidence Eliminated

The historically higher lung cancer incidence in young black people compared with white people has disappeared and reversed in men and women, respectively, in the United States, according to a study published in *JNCI Cancer Spectrum*. Study investigators examined the 5-year, age-specific lung cancer incidence in black and white people younger than 55 and calculated the black-to-white incidence rate ratios (IRRs) using incidence data from 1997 to 2016. In successive black and white men born since 1947 and women born since 1957, the 5-year, age-specific incidence decreased, with steeper decreases seen in blacks than whites. In men born 1967 to 1972, the black-to-white IRRs became unity and the IRRs reversed in women born since 1967. The historically higher sex-specific smoking prevalence in blacks compared with whites disappeared in men, while in women born since 1965, this prevalence reversed. The exception to these patterns was the higher incidence in black compared with white men born 1977 to 1982. “Although these patterns herald progress in reducing racial disparities in lung cancer occurrence and the success of tobacco control in the black community, the increasing lung cancer incidence rates in black men born circa 1977 to 1982 is concerning and underscores the need for targeted tobacco prevention interventions,” the authors write. ■

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PW
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