

## 33 ||| CHARTS

### Refusing Telemedicine – Can Patients Opt-out of Remote Care?

With the sweeping rise of COVID-19, telemedicine has taken healthcare by storm. During the local surges, this served as a mandated way of maintaining safe distancing. But as things come back to a new normal and as we decide where telemedicine fits in to a clinic structure, it might be worth asking: should patients have the option for in-person care? Is refusing telemedicine in favor of being physically seen a choice patients should be able to make? As we begin to settle in to a fixed role for telemedicine in the post-COVID world, centers are beginning to shape processes around telehealth.

Three assumptions that we make about patients and virtual encounters give shape to our policies:

#### ASSUMPTION OF APPROVAL

We assume that telemedicine is what patients prefer. The belief that patients prefer to be cared for in the context of their home isn't always the case. There may be sensitive issues or a hidden agenda that doesn't show well across a screen.

#### ASSUMPTION OF EQUIVALENCE

We assume that telemedicine is as good as in-person care. There is a bias to try to assess virtually some conditions that may best be assessed in real life. But, sometimes, medicine needs to be inconvenient.

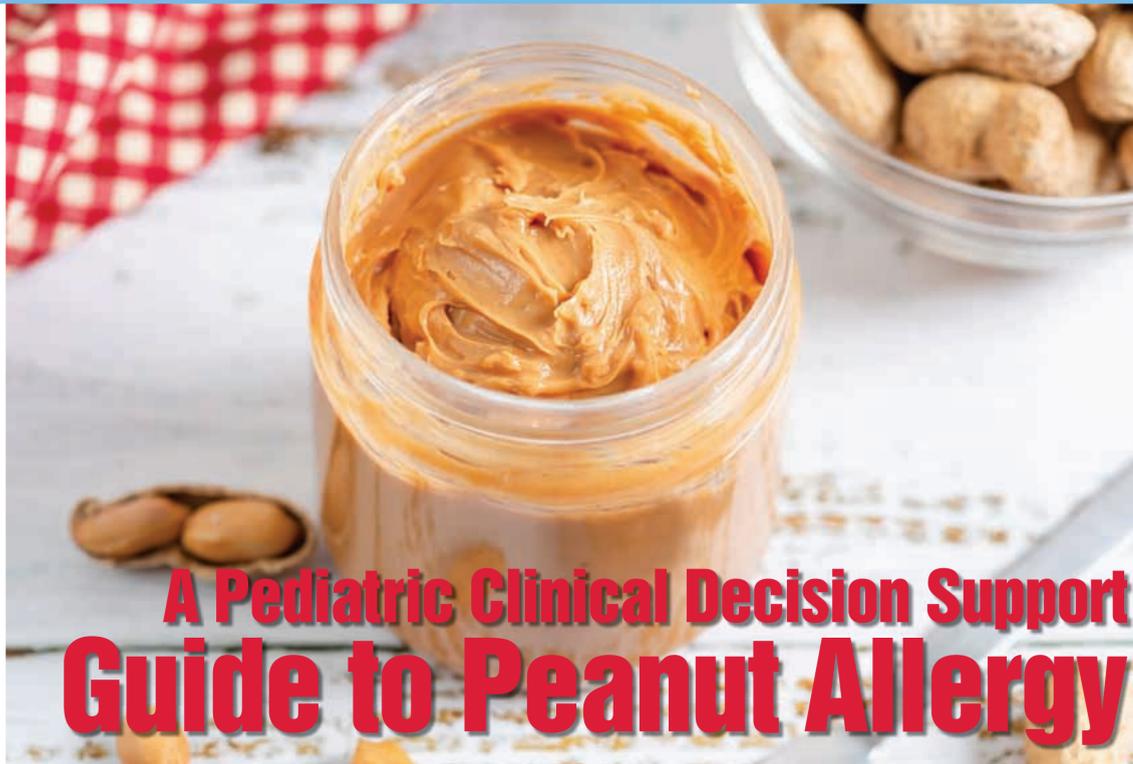
#### ASSUMPTION OF CAPACITY

We assume the patient is able to participate in a virtual visit. Some families lack Internet access and equipment to complete a telemedicine visit. Tech insecurity is a bigger issue than thought initially when we started doing telemedicine.

There are many reasons why a patient may prefer an in-person visit. Our assumptions about the magic of telemedicine are not always right. While we should work to accommodate the preferences of the patient, patients need to understand that there are conditions and circumstances where an in-person visit is not necessary. And patients should be offered the right of refusing telemedicine.

Will our telemedicine policies pull us back to an imbalanced doctor-patient relationship? After the COVID dust falls, we need to create more structure that respects the interests and will of the patient. Telemedicine is a moving target. What works or doesn't work today may have a very different solution or experience a year from now. Flexibility and rapid reiteration of our processes will be critical to successful adjustment and growth. ■

Visit [33charts.com](http://33charts.com) to read the full article.



## A Pediatric Clinical Decision Support Guide to Peanut Allergy

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Data indicate that peanut allergy is a growing epidemic, with a current prevalence of 2.2%, up from 0.8% in the early 2000s. Evidence suggests that parent and pediatric clinician concerns have grown in step with prevalence, as about one in 13 US children are now affected by food allergy. Of these, peanut allergy is the most common.

The groundbreaking Learning Early About Peanut (LEAP) study answered the question of why there has been a large increase in peanut allergy cases and whether it can be prevented from developing, while also providing evidence supporting the introduction of peanut in infants prior to their first birthday. In response, the National Institute of Allergy and Infectious Diseases (NIAID) published the 2017 Addendum Guidelines for the Prevention of Peanut Allergy (PPA guidelines). The PPA guidelines provide pediatric clinicians with instructions for evaluating infants for peanut allergy, triaging them into risk categories, recommending whether to introduce peanuts, and guiding clinicians to counsel parents on peanut introduction.

Disseminating the PPA guidelines to pediatric clinicians—with instructions contrary to previous AAP recommendation of peanut avoidance—and facilitating adherence with the guidelines have proven difficult.

Compounding the challenge, clinicians currently are often managing heavy patient loads in busy practices with limited patient time during 4- and 6-month well visits.

#### iREACH

A previously successful method for facilitating clinician guideline adherence is through clinical decision support (CDS) tools embedded in the electronic health record (EHR). Using this method, we and our colleagues developed the Intervention to Reduce Early (Peanut) Allergy in Children (iREACH), a pediatric clinician training module and set of EHR-based CDS tools. Embedded within 4- and 6-month well visits, the tools include:

- 1 | An order set for peanut-specific immunoglobulin (sIgE) testing or allergy referral for infants at high risk of peanut allergy.
- 2 | A reminder to evaluate infant peanut allergy risk.
- 3 | A prompt indicating peanut product introduction counseling.
- 4 | An instructional handout for clinicians to provide parents and caregivers.
- 5 | A best-practice advisory alert for infants with documented eczema or egg allergy.

For a paper published in *JAMA Pediatrics*, Lucy A. Bilaver, PhD, and colleagues conducted a pilot study to examine the effectiveness of the iREACH intervention. The intervention was implemented in one practice, while a second practice received no training modules or EHR modifications. Data was collected from 151 infants from the intervention practice and a random sample of 312 from the control practice (Table). The criteria for pediatric clinician adherence to the PPA guidelines was met if peanut introduction was documented in the EHR for those infants considered low-moderate risk for peanut allergy or sIgE testing and/or allergy referrals for those considered high-risk. Criteria for partial adherence was met if the parent or caregiver instructional handout was distributed to families of the low-moderate risk infants, even if recommendation of peanut introduction was not noted in the EHR.

#### Promising Results

Results from the iREACH pilot study indicated a significant difference between the iREACH intervention group and controls among low-moderate risk infants (Table). In the iREACH intervention group, pediatric clinicians were adherent to the PPA guidelines with 52.4% of infants seen; the control clinicians were adherent with only 14.1% of infants. Pediatric clinicians were partially adherent in 93.0% of infants seen in the iREACH practice. For infants at high risk for peanut allergy, results were inconclusive, as the sample size was too small for statistical significance.

Results from the iREACH pilot study suggest that a CDS tool may improve clinician adherence, but a more comprehensive study is needed. Thus, we have begun a randomized control trial in more than 30 pediatric clinics to investigate the effectiveness of the iREACH intervention on increasing pediatric clinician adherence to the PPA guidelines and reducing the incidence of peanut allergy in children by age 2.5. ■

Table Guideline Adherence

Outcome	iREACH Clinic	Non-iREACH Clinic	P Value
Infants at low-moderate risk	143	311	N/A
Partially adherent to guidelines	133	N/A	N/A
Adherent to guidelines	75	44	<.001
With peanut-specific IgE ordered	3	0	.03
With allergy referral	2	5	>.99
Infants at high risk	8	1	N/A
Adherent to guidelines	5	0	.44
With peanut-specific IgE ordered	2	0	>.99
With allergy referral	3	0	>.99

Source: Adapted from: Bilaver L, et al. *JAMA Pediatr.* 2019; 73(12):1198-1199.

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### Is There Life After Medicine?

By Brian Rifkin, MD

My group of nephrologists is trying to convince our 75-year-old colleague to retire from full-time clinical practice. I think he truly believes that the day he retires, his essence will be forcibly removed from his body, and he will cease to exist. He has told me, more than once, that he will be dead in less than a year if he is forced to stop being a physician. I envisioned this type of machismo was very old-school thinking, but maybe not. Modern doctors strive for a better balance of work and life, but do you ever really stop being a physician?

We all have many titles in life. What happens when the title remains, but the interactions cease? I strive to add quality and not just quantity to the lives of my patients who need to start dialysis. I have type 1 diabetes and realize that their reality may someday be mine. I hope to retire young enough that I can still enjoy all life has to offer.

In nephrology, where we have not been filling fellowship training spots, we are failing to replace ourselves in the workforce. There will likely be a need for me to prolong my work life. When I think about stopping my medical practice, I think about the million ways to not do medicine: volunteering, teaching, reading, writing, relaxing. I love interacting and helping patients. I do not, however, always enjoy the structural, administrative, and financial barriers imposed by day-to-day practice. This has been my point to my senior partner; why not take the best parts of medicine and only do those things that add meaning and pleasure to your life?

But is my partner correct? Do we lose something when we retire? There is some evidence that waiting to retire may have some health benefits. In a 2019 Swedish study, it was suggested that working past age 65 was associated with better overall health, but one can certainly argue cause and effect in this type of observation. Not debatable is that the average age of American physicians is increasing. In a 2017 survey by CompHealth, doctors reported an average retirement age of 68 (vs 63 for all Americans), and only 32% said they looked forward to no longer working in medicine. Losing social interactions at work, feeling a loss of purpose, boredom, loneliness, and depression may provoke an identity crisis at the end of a physician's career.

The ideal retirement means something different for every physician. However, it is clear that the valuable skills we acquire afford the opportunity to contribute long into our golden years. I hope that when I am 75, I have the choice to contribute (or not) as I see fit. There is purpose in being a doctor. The trap is when you assume all that you are is a doctor.

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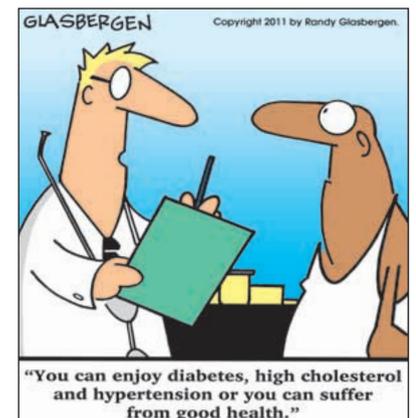
### In Case You Missed It

#### Most Pediatric Cases of Abusive Head Trauma Occur in Private Homes

Almost all cases of abusive head trauma (AHT) in young children occur in private homes, with the usual child care arrangement in most cases by a single adult in charge of one or more children, according to a study published in *Pediatrics*. Researchers conducted a multicenter retrospective study covering an 18-year period, which included medical and court records for 323 children (aged 2.5 months to 3 years) with AHT. The usual child care arrangement and child's location at the time of injury were recorded. Markers for abuse and forensic written reports were analyzed. The researchers found that in 98.5% of AHT cases, the assault occurred in a private home (four occurred in other indoor settings and data were missing for one case). Shaking occurred in a daycare center in one case, when a nurse was left alone with the infant for a few minutes. For 98.5% of cases, the usual child care arrangement was by a single adult in charge of one or more children. "Recent decisions to confine populations at home during pandemics set the framework for the importance and potential implications of this work," the authors write.

#### Breastfeeding Linked to Fewer Behavioral Difficulties for Children

Breastfeeding is associated with fewer parent-reported behavioral difficulties, which decrease further with longer duration of breastfeeding, according to a study published in the *Archives of Disease in Childhood*. Investigators examined data from the Millennium Cohort Study involving 11,148 children, their parents, and teachers to examine the longitudinal effect of breastfeeding on behavior in children aged 3-14. Even after adjustment for potential confounders, there was a correlation seen for breastfeeding with fewer parent-reported behavioral difficulties at all ages (breastfeeding duration: less than 2 months, 2-4 months, 4-6 months, more than 6 months:  $B = -0.22, -0.53, -1.07, \text{ and } -1.24$ , respectively;  $B =$  adjusted mean difference of raw Strengths and Difficulties Questionnaire at age 3, reference: never breast fed). "This study offers further evidence consistent with the idea that breastfeeding plays a crucial role in children's socioemotional behavioral development," the authors write. "Longer breastfeeding durations are associated with fewer behavioral problems in the short and long terms, though future research is required to illuminate the mechanisms." ■



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