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A Physician's Guide to Surviving COVID Winter

By Rada Jones, MD

How can you survive this winter holding on to your temper, family, and job? Look out for #1. That's you. To care for others, you must care for yourself first. That's not selfish. That's smart. To protect those who need you, you must stay healthy and sane. How? These are my tips.

1 | Set rules for others and for yourself | Your sleep should be sacred. So should whatever time off you can schedule.

2 | Enlist help | So many grateful folks want to help healthcare workers. Your neighbors may be glad to walk your dog, run some errands, or grab a gallon of milk.

3 | Prioritize yourself | Pay someone to plow, buy groceries online, hire a housekeeper to save time for the things that really matter.

4 | Schedule time for yourself to exercise, meditate, pray, journal—whatever helps fill your well.

5 | Shut off the TV | Whether you're Democrat or Republican, you won't enjoy the news. Watch the Nature Channel, Hallmark, or the Food Channel. Watching food is fun, and it won't make you fat.

6 | Go outdoors | There's magic in nature and sunlight, whatever's left of it. Hike, snowshoe, and allow your lungs to breathe real air instead of the conditioned germs they allow you in the hospital.

7 | Say no | That's a survival technique. Say no to parties, hugging strangers, doing things you shouldn't, and protecting others' feelings. Let them take care of their feelings. You take care of yourself.

8 | Cut yourself some slack | You aren't perfect. Nobody is. You'll make mistakes, gain a few pounds, step on some toes, maybe even lose it at times. So what? Just do the best you can.

9 | Read a book | Remember those things made of paper? You turn a page and land in a new world?

10 | Be careful with alcohol and substance use | They may feel good at the moment, but you'll be worse off in the long run.

11 | Watch old movies that make you laugh.

12 | Take a break from social media | Picking fights with random strangers won't help your mental health. Cut off those who hurt you.

13 | Get a cat | They have nine lives; that's why they are masters of survival. They ignore all unpleasantness, and they'll show you how. And they're the best nap helpers.

14 | Communicate | Ask coworkers how they handle the stress. They may teach you something, and if they don't, sharing the burden will help you both.

15 | Seek help before you lose it | Check out the CDC's resources on stress and coping.

16 | Pat yourself on the back | You're a darn hero! In recycled PPE, instead of shining armor, you saved fair maidens of all genders, ages, and persuasions. With a vaccine in sight, there's a light at the end of the tunnel.

Wishing you all health, joy, and happiness. See you all on the other side.

Rada Jones is an emergency physician and can be reached at her self-titled site, RadaJonesMD.com, and on Twitter @jonesrada. She is the author of *Overdose*.



Chronic Neuropathic Pain Following Burns: Assessing Prevalence & Predictors



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A study provides clarity on the prevalence of patients with burns developing chronic neuropathic pain (CNP) in the years following their injury. The investigation reveals several factors that are associated with developing CNP following burn injury, some of which are modifiable.

Research shows that patients with burns can develop chronic pain that is sometimes unrelated to the initial burn itself. Chronic neuropathic pain (CNP) can develop after partial or complete peripheral nerve injuries among this patient population. This pain can significantly decrease quality of life (QOL) and often leads to long-term morbidity that limits functional recovery.

"Previous studies report that the prevalence of CNP following burns ranges from 7.3% to 82.0% spanning the years of 1989 to 2013," says Kevin M. Klifto, PharmD. "Considering this wide range, a better understanding of the true prevalence of CNP following burns and associated predictors of CNP may help healthcare providers (HCPs) in their care of these patients. Some HCPs may be unaware of the signs and symptoms of burn-related neuropathic pain or how it impacts QOL. Furthermore, chronic pain—regardless of its origin—often has a stigma associated with opioid-seeking behavior, and many patients do not receive the appropriate attention they may deserve."

Prevalence & Risk Factors for CNP

For a study published in *Burns & Trauma*, Dr. Klifto and colleagues sought to determine the prevalence and associated predictors for CNP in patients with burns. The retrospective analysis included 1,880 patients older than 15 who were admitted to an adult burn center between 2014 and 2019. CNP was diagnosed clinically following the burn injury. Data from patients admitted to the burn center with no pain were then compared with data from those admitted to the burn center who subsequently developed CNP. The median patient follow-up was 27 months.

"A goal of our study was to determine the prevalence of CNP among patients with burns, but we also wanted to identify risk factors associated with CNP following burns," says Dr. Klifto. "By identifying factors that contribute to CNP, HCPs could potentially predict who might develop this pain and seize opportunities for earlier interventions to prevent long-term suffering and potentially improve a patient's QOL."

According to the results, 113 burn patients—or 6.01%—developed CNP as a direct result of their burn injury during the 5-year study.

Patients who developed CNP were significantly older, with a median age of 54, compared with a median age of 46 in the no-pain group. "Patients with burns who developed CNP were more likely to abuse alcohol or other substances and were more likely to be current smokers," Dr. Klifto says (Table). "We also found that a greater number of burn-related surgeries and longer hospital length of stay (LOS) were associated with developing CNP." In addition, patients who developed CNP suffered more full-thickness burns, had a greater percent of total body surface area burns, and were more often intubated on mechanical ventilation.

Awareness & Prevention

When managing burn injuries, Dr. Klifto notes that public awareness and prevention are important considerations. "Alcohol abuse, substance abuse, and/or smoking may increase risks for developing CNP following a burn, but these are all potentially modifiable risk factors that patients can address by making lifestyle changes," he says. "However, the number of surgeries and hospital LOS may not be modifiable depending on the extent of the burn injury and other comorbidities. In these cases, preventative measures or more frequent follow-up visits may be helpful to monitor for signs and symptoms of CNP and allow HCPs to potentially provide early interventions."

In light of the findings, Dr. Klifto says additional prospective studies that monitor the identified predictors of CNP in patients with burns may provide more conclusive insights. "It would also be helpful to determine the number of surgeries and number of days in the hospital that favor risks over benefits so that we can provide guidance for HCPs managing acutely burned patients," he says. "In addition, investigating the early initiation of preventative therapies in high-risk patients may help us better understand the pathophysiology involved with developing CNP following burns. As these data emerge, we hope to improve our care of patients with burns and reduce their risks for developing CNP." ■

Table Predictors of CNP

The table below depicts odds ratios (ORs) of developing chronic neuropathic pain (CNP) following burn injury, as assessed by multivariate analysis.*

Comparison	OR	95% CI	P Value
Age, years	1.01	0.99–1.03	0.080
Alcohol abuse	2.04	1.06–3.94	0.030
Substance abuse	3.12	1.65–5.93	<0.001
Current daily smoker	6.91	3.72–12.67	<0.001
%TBSA	1.01	0.99–1.03	0.340
Full-thickness burns	1.83	0.46–1.96	0.510
Intubation/ventilation	1.91	0.98–3.73	0.060
Number of surgeries	7.51	2.91–19.21	<0.001
Hospital LOS, days	1.01	1.00–1.02	0.010

Abbreviations: CI, confidence interval; %TBSA, percent of total body surface area; LOS, length of stay.

Source: Adapted from: Klifto K, et al. *Burns Trauma*. 2020;8:tkaa011.



Dealing With Non-Compliant Patients: Using Facts in Your Defense

The following is a continuation of the MedLaw column in the January issue.

If, despite your best efforts, your patient suffers a poor outcome and you are being sued for malpractice, you would ideally like to stop the process before it reaches the courtroom. To that end, your attorney would file a Motion for Summary Judgment, asking the judge to dismiss the case as a matter of law because the plaintiff cannot meet their burden of proof. The plaintiff would be required to "lay bare their proof" that it was actually your conduct that was the proximate cause of the harm.

The judge may decide the Motion on papers alone or may hold a hearing at which the attorneys can offer argument but there will not be any witnesses called. Your "witness" will, therefore, be the medical record. Courts generally loathe to deny a plaintiff their day in court, and so the record must be very clear as to the patient's resistance to your efforts to work with them and your informing them of the serious consequences of their non-compliance and of the likelihood that it would cause the very harm that they then suffered.

If this Motion fails and the matter proceeds to trial, you still have strong defenses to raise based on the patient's non-compliance:

▶ **Contributory negligence** is an archaic defense that is still retained in few jurisdictions. It holds that a plaintiff who has any fault at all in their injuries may not recover damages for those injuries. If you are in one of those jurisdictions, your ability to demonstrate that patient non-compliance contributed at all to the claimed harm will bar any recovery against you.

▶ **Comparative negligence** does exactly what its name implies: it compares the level of fault for each side. In some jurisdictions, no amount of plaintiff fault bars recovery, and in others, there is a cut-off beyond which the plaintiff is barred. If a case goes through, any recovery will be offset by the proportion of the plaintiff's fault. In any comparative negligence jurisdiction, patient non-compliance will be a critical issue, because even if the case is not barred and the patient wins, damages will be reduced.

The plaintiff's duty of mitigation applies to the conduct of the patient after a harm has been recognized. Plaintiffs must show that they did what they reasonably could to minimize the effect that the negligence for which they are suing had on them. Even if you do have actionable liability for an error of your own, a patient non-compliant with well-advised recommendations for correction comes into evidence and acts as a damages offset.

When dealing with a persistently non-compliant patient, think ahead to how you would counter a malpractice claim when you create the record. A clear contemporaneous record of the patient's ongoing non-compliant conduct despite your efforts to have them act in a medically responsible way is the key to a solid defense.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney.

In Case You Missed It Therapeutic Suggestions During General Anesthesia Cut Pain

For patients undergoing surgery, therapeutic suggestions played through earphones during general anesthesia can reduce postoperative pain and opioid use, according to a study published in *The BMJ*. Researchers conducted a blinded randomized controlled study in five tertiary care hospitals in Germany involving patients recruited from January to December 2018 who were to undergo surgery under general anesthesia. A total of 191 patients were included in the intervention group, which was assigned to an audiotape of background music and positive suggestions based on hypnotherapeutic principles that was played repeatedly through earphones during general anesthesia; 194 patients were included in the control group and were assigned a blank tape. The intervention group required a significantly lower opioid dose within 24 hours after surgery compared with the control group, with a median of 4.0 mg morphine equivalents versus 5.3 mg morphine equivalents and an effect size of 0.36. In the intervention group, the number of patients who needed opioids postoperatively was reduced (63% vs 80% in the control group). Within 24 hours after surgery, pain scores were consistently and significantly lower in the intervention group, with an average decrease of 25%. "This trial is very much the beginning of an important line of inquiry that may change future practice," write the authors of an accompanying editorial.

Individualized Montor Skills Training for Low Back Pain

Patients with chronic low back pain can learn new, practical and less painful ways to move through individualized motor skills training (MST), according to a study published in *JAMA Neurology*. The 2-year study of nearly 150 patients found that MST appears to better relieve disability from lower back pain than a more common but less-tailored exercise regimen broadly focused on improving strength and flexibility. With no accepted standard of care for chronic lower back pain, nor a clear sense of what type of exercise intervention might work best, the researchers randomized patients aged 18-60 with non-specific lower back pain for at least 1 year to strength and flexibility treatment for the trunk and lower limbs or MST that was meant to teach patients new ways to carry out everyday tasks rendered difficult by back pain. Both groups received 6 weeks of training for 1 hour per week. Half of each group also received three "booster" treatment sessions 6 months later. Disability questionnaires were completed at baseline, 6 months, and 1 year. While both groups' ability to perform daily functions without pain improved, the MST group achieved significantly better gains during the study period. MST patients were more satisfied with their care and less likely to use drugs for back pain. They were also less fearful of addressing work-related needs and less likely to avoid normal daily activities. ■

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