

MEDPAGE TODAY'S

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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 | 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 reconditioned 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.

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Integrated Fragility Hip Fracture Program Improves Outcomes



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While hip fracture carries a high risk of associated morbidity and mortality, previous studies of co-management indicate that orthopedic surgeons and internists working side by side, each within their own knowledge base, results in better outcomes than with either working as a consultant to the other, explains

Jensa C. Morris, MD. "At Yale, we initiated the co-management model in 2012 with reductions in inpatient mortality and complications," she notes. "But we found that working together was only the first step in building a comprehensive hip fracture program. We recognized that the medical complexity of these patients requires involvement of a more extensive team, including our emergency department, orthopedic nursing, pharmacy, care management, and rehabilitation colleagues. The focus needed to expand from the co-management surgeon-internist dyad to a comprehensive hip fracture team with standardized protocols and outcome monitoring."

Guiding Best Practices

With a wealth of research to guide best practices in the care of patients with fragility hip fractures—including literature on pain management, femoral nerve blocks, DVT prophylaxis, pre- and post-operative radiography, blood management, and pneumonia and delirium prevention—Dr. Morris and colleagues sought to determine their Yale Integrated Fragility Hip Fracture standard of care at all decision points, from EMS arrival and emergency department (ED) evaluation to preoperative evaluation, time to the operating room, postoperative care, and transition to home or rehabilitation. After extensive literature review and team consensus, the guidelines (Table) were hardwired into order sets to limit deviation. Results of their efforts are published in the *Journal of Hospital Medicine*.

"The intent was never specifically to publish a study," notes Dr. Morris, "but to build a program that best served the patients. The only way to know if we were successful was to monitor the outcomes meticulously. We reviewed inpatient and 30-day mortality, medical and surgical complications, and time to OR quarterly. Interventions were added iteratively as data became available and our groups progressed to consensus. There was never a true before and after, as we continue to assess and modify protocols."

Substantial Improvements

"It wasn't until 2 years into the program that we realized that each individual intervention and standardization of process had added up to substantial improvements in outcomes and in

30-day mortality," explains Dr. Morris. Indeed, implementation of the Integrated Fragility Hip Fracture Program was associated with a 30-day mortality reduction, from 8.0% in 2015 to 2.8% in 2018. Significant improvements also occurred in blood transfusion use (from 46.6% to 28.1%), adverse effects of drugs (from 4.0% to 0.0%), length of stay (from 5.12 to 4.47 days), unexpected return to the operating room (from 5.1% to 0.0%) and time to the OR of less than 24 hours (from 41.8% to 55.0%).

"There wasn't one single intervention that made the difference," Dr. Morris notes. "It was a series of interventions that ultimately impacted the mortality of this patient population. One could also hypothesize that this is simply the effect of a highly reliable team working together with shared goals and clear expectations. Regardless, the entire process of evidence-based protocols introduced in a standardized fashion had the outcome of reducing mortality."

Helping Others Build Successful Programs

Dr. Morris and colleagues hope that sharing their processes and outcomes can help others build successful programs within their institutions. "The first, most important step is to build a co-management team," Dr. Morris adds. "Rotating hospitalists through a consult service will not provide the same standardized, high-quality care. The program cannot be built overnight. Even in areas in which the evidence is clear, the individual structure of each hospital will require unique problem solving and solutions. One cannot simply take our order sets and apply them. This principle can be applied to any complex patient care process. And certainly, we are starting to see better inter-departmental partnerships within our academic medical centers to care for other complex patient populations, such as those with stroke, heart failure, and cancer." ■

Table Care Processes Included in the Integrated Fragility Hip Fracture Program

CARE PROCESS	DESCRIPTION
Preoperative	
ED order set	ED order set for suspected hip fracture includes ED protocols, staphylococcus PCR screening, and vitamin D assay to ensure early availability of tests for inpatient team
Standardized, magnification-controlled, ED radiography	AP pelvis, hip AP and lateral films, and femur AP and lateral films to evaluate for hip fracture
Hip fracture alert	Communication from ED staff to orthopedics, anesthesia, and internal medicine hospitalist of hip fracture patient in the ED
Femoral nerve block	Single-shot femoral nerve block offered in the ED to all eligible patients
Admission order set	Orthopedic hip fracture order set including all hip fracture protocols
Medical co-management	All patients admitted to on-call orthopedic surgeon service with medical attending co-managing from admission to discharge
Surgical site infection prevention bundle	Staph PCR screening, nasal decontamination, chlorhexidine bath, and perioperative antibiotic algorithm
Pain management protocol	Pain medications selected and dosed for the geriatric population and integrated into order sets
Preoperative checklist	Review of all necessary preoperative steps
Patient engagement	Verbal counseling and written brochures provided to patient and family; Patient engagement survey at discharge
Intraoperative	
Hip fracture on-call surgeon	Shared community and faculty orthopedic hip fracture call schedule
Hip fracture OR block time	Dedicated hip fracture OR block assigned daily
Tranexamic acid administration	Perioperative tranexamic acid protocol to reduce blood loss
Postoperative	
Postoperative order set	Orthopedic hip fracture order set including all postoperative hip fracture protocols and standardized radiographic imaging for quality assessment
Standardized DVT prophylaxis	Sequential compression devices unless ambulating. Preoperative SC heparin and postoperative enoxaparin
Blood management protocol	Restrictive blood transfusion protocol and perioperative tranexamic acid use
Nutritional optimization	Malnutrition screening, reduced NPO time, preoperative carbohydrate loading, and high protein nutritional supplementation
Pneumonia prevention bundle	Interventions to reduce perioperative pneumonia: early mobilization, avoidance of PPIs, out of bed for meals, and daily teeth brushing
Early mobilization	Out of bed before breakfast the morning after surgery

Abbreviations: AP, anterior posterior; DVT, deep vein thrombosis; ED, emergency department; NPO, nil per os; OR, operating room; PCR, polymerase chain reaction; PPI, proton pump inhibitor; SC, subcutaneous.

Source: Adapted from: Morris J, et al. *J Hosp Med.* 2020;15(8):461-467.



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 Guidance Provided for Antibiotic Stewardship in Pediatrics

In an American Academy of Pediatrics (AAP) policy statement, published in *Pediatrics*, guidance is provided for inpatient and outpatient antibiotic stewardship. The authors discuss inpatient and outpatient antibiotic stewardship programs (ASPs) in pediatrics, including essential personnel, infrastructure, and activities needed. They note that the AAP and Pediatric Infectious Diseases Society recommend establishing ASPs to improve antibiotic prescribing; the ASPs should include specialists with pediatric expertise. Ideally, inpatient ASPs should include a medical director and clinical pharmacist, both with expertise in pediatric infectious diseases and/or antibiotic stewardship. Core interventions for inpatient ASPs can use clinical guidelines, prior approval, and post-prescription review and feedback. Pharmacy-driven interventions can be included in inpatient ASPs. Standardized approaches for antibiotic prescribing, including clinical guidelines and/or decision support, should be considered for outpatient primary care practices, urgent care clinics, and emergency departments. Outpatient stewardship can focus on judicious antibiotic use and can emphasize use of the narrowest-spectrum antibiotics for the shortest duration of therapy to adequately treat infections.

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%. ■

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