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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 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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Reducing Unnecessary Opioids After Total Hip Arthroplasty



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“There has been very little practical guidance on how to consistently implement reductions in prescribed doses, how to safely taper opioids after surgery, and how to personalize opioid prescribing to ensure that patients continue to receive effective pain management,” states Edward R. Mariano, MD, MAS. In line with national efforts by the American Society of Anesthesiologists and National Academy of Medicine, Dr. Mariano and colleagues tackled the problem of opioid over-prescribing at the local level by developing a tool that could be rapidly implemented.

Testing an Opioid Prescribing & Tapering Protocol

For a retrospective cohort study, published in *Pain Medicine*, the team tested the hypothesis that implementing a multidisciplinary, patient-specific discharge protocol for prescribing and tapering opioids after total hip arthroplasty (THA) would decrease the morphine milligram equivalent (MME) dose of opioids prescribed. “At our hospital, patients who undergo lower extremity joint replacement surgery receive their care in a collaborative perioperative surgical home (PSH) model of care,” explains Dr. Mariano. “The PSH model facilitates regular communication between members of the healthcare team

and promotes continuous process improvement. We chose to design a protocol that could be variable and patient-specific.”

The study team created a tool that calculates each patient's total number of oxycodone tablets to be prescribed at discharge based on opioid consumption in the prior 24 hours, along with explicit instructions on how to taper the dosage and when (Table). “We avoided analgesics that combine an opioid with acetaminophen so patients could continue to take the maximum allowable daily dose of acetaminophen as part of their multimodal analgesic regimen,” notes Dr. Mariano. “We avoided prodrugs since the analgesia and side effects vary between individuals based on metabolism. We also attempted to keep the tool as simple as possible by using the prior 24-hour opioid consumption as the highest allowable dose and setting the taper downward from there every 2 days. Patients were given instructions to monitor for signs of withdrawal as well as recommendations for safe opioid storage and disposal. Patients who have received no opioid in the prior 24 hours should be given the option of going home without opioids rather than prescribing them unnecessarily.” Dr. Mariano and colleagues analyzed the PSH database and prescription data for all patients who underwent primary total hip arthroplasty 3 months before and 3 months after implementation of the new protocol.

“A Huge Difference”

The total median MME for 6 weeks postoperatively was 900—ranging from 57 to 2,082—

during the 3 months prior to the intervention, compared with 295—ranging from 69 to 741—during the 3 months after. While refill rates did not differ, median initial discharge prescriptions in MME were 675—ranging from 57 to 1,035—prior to the intervention and 180—ranging from 18 to 534—after. “No aspect of our inpatient perioperative pain management protocol changed,” notes Dr. Mariano. “All patients received multimodal analgesia, and there were no differences in patients' inpatient opioid usage, postoperative adverse events, or recovery trajectory that could account for the difference in prescribed opioid amount seen in our results. This emphasizes that discharge opioid prescribing prior to implementing our patient-specific protocol was arbitrary and that applying our new tool made a huge difference.”

Expanded Application

With these results showing it is feasible to develop a simple tool to guide discharge opioid prescribing and tapering for THA patients, according to Dr. Mariano, the researchers have applied the tool for all major orthopedic and spine surgery patients. “Not all physician practices may be able to use our tool in its current form since we have a PSH model of care and unique patient population,” he notes. “However, every practice can implement multimodal analgesia protocols, assess their patients' opioid use, and develop a similar tool that accounts for their patients' inpatient opioid consumption when determining how much opioid to prescribe at discharge with tapering instructions.” ■

Table Discharge Opioid Protocol

The table below shows a discharge opioid prescribing and tapering protocol based on each patient's prior 24-hour oral opioid use.

Prior 24-hour Oxycodone	Tapering Instructions (Prescribed As-Needed)						Total Oxycodone 5 mg Tablets Prescribed
	Days 1-2	Days 3-4	Days 5-6	Days 7-8	Days 9-10	Days 11-12	
10 mg	5 mg twice daily						4
20 mg	5 mg four times daily	5 mg twice daily					12
30 mg	5 mg six times daily	5 mg four times daily	5 mg twice daily				24
40 mg	10 mg four times daily	10 mg three times daily	5 mg four times daily	5 mg twice daily			40
50 mg	10 mg five times daily	10 mg four times daily	10 mg three times daily	5 mg four times daily	5 mg twice daily		60
60 mg	10 mg six times daily	10 mg five times daily	10 mg four times daily	10 mg three times daily	5 mg four times daily	5 mg twice daily	84

Source: Adapted from: Tamboli M, et al. *Pain Med.* 2020;21(7):1474-1481.



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 Recommendations Developed for Management of Lyme Disease

In new evidence-based clinical practice guidelines, published in *Clinical Infectious Diseases*, recommendations are presented for the prevention, diagnosis, and treatment of Lyme disease. The guidelines were developed by a multidisciplinary panel led by the Infectious Diseases Society of America, the American Academy of Neurology, and the American College of Rheumatology. The authors summarized recommendations related to diagnostic testing, detailed recommendations for Lyme carditis, and chronic Lyme disease. According to the report, individuals at risk for exposure should implement personal protective measures, including repellents to prevent tick bites and removal of attached ticks. The removed tick should be submitted for species identification. Prophylactic antibiotic therapy should be given to adults and children within 72 hours of removal of an identified high-risk tick bite; oral doxycycline is recommended within 72 hours of tick removal for high-risk Ixodes species bites in all ages. Intravenous ceftriaxone, cefotaxime, penicillin G, or oral doxycycline are recommended over other antimicrobials in patients with Lyme disease-associated meningitis, cranial neuropathy, or radiculoneuropathy or with other peripheral nervous system manifestations. Hospital admission with continuous electrocardiogram monitoring is recommended for patients with or at risk for severe cardiac complications of Lyme disease. Oral antibiotics are suggested over intravenous antibiotics for outpatients with Lyme carditis. Additional antibiotics are not recommended for patients with persistent or recurrent nonspecific symptoms following recommended treatment for Lyme disease.

Rare Autoimmune Rheumatic Disorders Deaths Up

Individuals with rare autoimmune rheumatic diseases (RAIRD) have a more prominently increased risk for all-cause death during COVID-19 compared with the general population, according to a study published in *Rheumatology*. Investigators conducted a cohort study to quantify the risk for death among people with RAIRD during the COVID-19 pandemic. Data included from 168,691 people with a recorded diagnosis of RAIRD alive on March 1, 2020 (median age, 61.7; 70.2% female). The researchers found that 1.1% of participants died during March and April 2020. The age-standardized mortality rate was 1.44 times higher among people with RAIRD than the average during the same months of the previous 5 years, whereas it was 1.38 times higher in the general population of England. In people with RAIRD, age-specific mortality rates were higher from age 35 and upward compared with the pre-COVID-19 rates, while in the general population, the increased risk was observed from age 55 and upward. Compared with men, women had a greater increase in mortality rates during COVID-19. ■

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