

MEditorial February 2013

“Take a Walk with Me”

Take a walk with me around the hospital. You will notice some interesting trends. On some floors, almost 50% of the patients are “on isolation”. This is to protect transmission of bacteria they harbor to other patients. Those entering the room have to take special precautions such as wearing gowns, gloves, and masks. Although infection control specialists will extol the importance of meticulous hand washing by healthcare workers, it is not dirty hands that landed patients in these rooms. It is undoubtedly the overuse of antibiotics, both in and out of the hospital, that allows for the evolution of new virulent bacterial strains, some of whose names you may have heard: MRSA (methicillin-resistant Staph); VRE (Vancomycin-resistant enterococcus); C. diff. (Clostridium difficile). Such infections are difficult to treat and have a much higher chance of causing serious/life-threatening complications than garden-variety bacteria. My observation and bias is that far too many patients are receiving antibiotics in doctors’ offices, urgent care centers, emergency rooms and by “over-the-phone”. It seems when someone is ill and the doctor “can’t figure it out”, a prescription for an antibiotic is the answer--and at least temporarily makes the patient feel that the physician “is doing something for my problem”. When lab tests for bacteria can easily be done before antibiotics are prescribed, such as culturing the urine, this is often overlooked or not done due to “cost” concern. If a bacterial culture is done, patients may be unaware of the need to call the treating doctor in a few days to verify the result; see if antibiotics are really needed and whether a change to a different drug is mandated.

A related problem is the fragmentation of care. When a patient is seen over several weeks/months by a multitude of providers, the chance for error or overtreatment increases. A patient of mine was hospitalized twice in the last month, 1st for “the flu” and pneumonia, receiving antibiotics then. Soon thereafter, he was re-admitted with inability to urinate and chest pain. He was seen by a different hospital doctor. When he experienced urinary bleeding from his catheter after being discharged from the hospital [and he called his primary

care doctor], he was treated over the phone for this with antibiotics, without any evidence the bleeding was related to any infection. Later in the week, another ER visit, for a poorly functioning urinary catheter, resulted not only a change in catheter, but also another antibiotic prescription. Unaware of any urine culture result, he remained on what was, in retrospect, an inappropriate antibiotic until yet another ER visit for bladder spasms, when the 2nd ER doctor checked the prior culture, discovered the growth of a fungus in the urine, and switched this man to an antifungal agent.

Patients of mine who have abnormal urinalyses due to recent prostate or bladder surgery, or due to irritation of the urinary lining by stones, are apt to be placed by an urgent care/ER/primary care doctor on antibiotics for this finding—perhaps born out of fear that if antibiotics are not used immediately to “quell” this lab finding, the patient will become horribly ill. The opposite is more likely, i.e., illness from the antibiotic itself, or ultimately ending up on hospital isolation due to chronic overexposure to these drugs.

Walk with me into the hospital ICU’s. Most of the patients are elderly. Statistically, it probably makes sense that older folks, with deteriorating physical condition, will develop more grave conditions needing critical care. Some of these patients have no local family with whom we doctors can discuss the appropriateness of this level and intensity of care. Others have next-of-kin who “want everything done” to try to stop the downward spiral. There is no arbiter of benefit-versus-risk of intensive care. Although the expensive cost of such care in the last stages of life should be an issue, health care providers do not feel comfortable or empowered to discuss such things; and the patient’s family knows “someone else” is paying for it all. Should patients with end-stage cancer or advanced Alzheimer’s, to cite a few examples, where there is no hope of meaningful survival, be placed in an ICU bed? Should they, even though in some cases, a less aggressive but more humane approach may mean death in days to weeks? Should we as doctors always do the “medically correct” thing without acknowledging the context of the patient? Yesterday, I consulted on a critically ill 92 year old lady with urosepsis (systemic manifestations of bacterial infection originating in her urinary tract) likely due to pus being trapped in one kidney

behind a ureteral stone. The “correct” medical remedy would be insertion of a “bypass” tube (stent) into the affected kidney to drain the pus, followed perhaps weeks later by some a minimally invasive attempt to eradicate the offending stone. This could temporarily make her better--but it is likely she would continue to be ill and deteriorate toward death. The lady, in her baseline function, cannot move or speak, does not understand her surroundings, punches at healthcare workers trying to help her, and has--what most sensible people would agree--is a miserable quality of life.

When my father, impaired and living in a nursing home for 2 years with complications of brain tumor treatment, suddenly aspirated food and had pneumonia/respiratory arrest, those caring for him overlooked a healthcare “durable power of attorney” not to resuscitate him. He was aggressively treated in the local ER and moved, on a ventilator, to the hospital’s ICU. A chest tube was soon placed for a ventilator-induced lung rupture causing air to compress a lung from the outside. By the time my mom called me, a lot had been done. But we decided to put an end to it. By the next day, dad had these tubes out, and was moved to a hospice room, his pain and breathing issues palliated with narcotics. He died several days later, in dignity. I keep a picture, in my cellphone, of me standing behind his hospital bed; and one can see a sense of serenity, almost a smile on his face, with two days left to go.

Take a walk with me to the clinical wards or the operating room. Patient care and proper utilization of doctors’ time is delayed and sometimes impeded by a growing mountain of federal and state bureaucracy. In the hospital, it is not uncommon for there to be up to 60 minutes between the end of one of my surgeries and the start of the next. We surgeons do not get reimbursed for sitting around--and the hour is insufficient for us to return to get work done in our offices. Similar cases, if done in an ambulatory surgery center, can flow smoothly, with perhaps 15 minutes between cases. Such centers are not, however, as overbearingly regulated as are acute care hospitals. Risk aversion has taken precedence over getting things done in an expeditious and sensible manner. In the operating room, “time outs” are held, before the operation can proceed, to be sure all in the room identify the patient, and know the name/surgical site of

the intended procedure. Those announcing the procedure often cannot pronounce the name of the operation, nor do they themselves understand what it is; in fact, the surgeon is often the only one in the room with any relationship to the patient! Look at the hospital nurses' preoccupation with completing mandated paper and computer forms, documenting everything, perhaps pleasing to government regulators and lawyers, but detracting from their personal interaction with and "getting to know" patients. A recent random audit of the hospital by the federal body that oversees Medicare payments led to a required test to be passed by all physicians, or "face suspension". The answers were, in essence, to be memorized, since these auditors would be returning and could--at their will--pick any doctor in the hospital hallways and ask him/her to answer a question about his and the hospital's compliance with a certain "rule". The questions seemed to strangely obsess over such "urgent" patient care matters as who has the authority to fax patients' records from one healthcare institution to another; proper unit refrigeration temperature for patients' food; and how a surgeon should properly bring his own specialized equipment and instruments into the operating room.

Those of us who have been practicing medicine for a long time do not like these trends. It makes us want to not "take a walk around the hospital". The somewhat oppressive atmosphere (amidst other financial reasons) indirectly explains why hospitals are more and more hiring salaried physicians, who will go along with the new trends in healthcare and unfortunately can be manipulated at the whim of administrators.

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