

Take 3 – Practical Practice Pointers[©] August 26, 2019 Edition

High Risk Med Monitoring, Pancreatic CA, Microaggression Part 1

From the World of Quality and Safety and a Colleague's Question

1) Discontinuing Meds for Patients Who Don't Follow-Up ... Reprise

Question:

What should be the process for managing patients who are on ACE-I, ARBs, thiazide diuretics or digoxin who have not had a BMP/drug level in the past 12 months and have not followed-up despite requests to do so?

Answer:

Last year, this question was discussed by our Ambulatory Clinical Advancement and Patient Safety Committee (A-CAPS – previously known as the Ambulatory Quality Committee). The clinical dilemma in the case of BP meds, for example, is that stopping/not refilling the medication could cause a patient to have uncontrolled HTN, but not stopping the medication could mean that their kidney function or serum sodium/potassium could be abnormal without our being aware of it. Both are potential safety issues.

After multiple meetings and rich discussion, guidance from the A-CAPS committee includes the following:

- We should have a consistent approach across all departments.
- We should be deliberate about educating our patients regarding follow-up and laboratory monitoring expectations at the initiation of treatment and/or when a refill request is made and should document this in their health record (a dot-phrase is the easiest way to do this).
- For patients on the medications noted above, a BMP blood test should be performed at least yearly (aiming for twice yearly) or more frequently at the discretion of their clinician in the context of their overall health.
- If the patient requests a refill and is due for a follow-up and/or lab testing (13-15 months at most – 13 months if they have been given a “1 month + 12 refill” or 15 months if given a “90 days + 4 refill”), a phone call should be made and the patient informed that it is past time for a follow-up visit and lab study.
- At that time, they should be given a 1 month refill, instructed to follow-up within the month, and told if they don't follow-up in this time period, their medication will not be refilled until they do so. This conversation should also explore if there are particular barriers to the patient following-up, and an attempt made to address these barriers. Documentation of this conversation should be made in the chart, preferably with a smartphrase. A phone call is preferable to a letter to insure the patient received the message, but could be accompanied by a follow-up letter as well if desired.
- If the patient doesn't follow-up during this time period, the medication should not be refilled and should be removed from their active medication list.
- Once the patient does follow-up (if they do so), consideration should be given to placing them on a medication that does not require laboratory monitoring. Even so,

the medication should not be continued beyond the period of time their clinician feels is safe without monitoring (in this case, for BP monitoring).

- Patients who don't follow-up should **not** be dismissed from the practice.
- A similar approach should be considered for other medications.

My Comment:

Being consistent as to how these patient care “dynamic tensions” are navigated is important from both a quality/safety and risk/legal perspective. Continuing to prescribe any medication indefinitely without follow-up should never be considered appropriate (or wise) medical care. This question also brought to light two other “Pointers” for your consideration: 1) Using the 90 days plus 4 refills approach to refill management (90+4) for many chronic medications, and 2) The importance of regular medication reconciliation within our patient’s health record.

Reference:

Carilion Clinic Ambulatory Quality and Patient Safety Committee (A-CAPS) 2018

From the USPSTF

2) Screening for Pancreatic Cancer

Pancreatic cancer is an uncommon cancer with an age-adjusted annual incidence of 13 cases per 100,000 person-years. However, the death rate is 11 deaths per 100,000 person-years because the prognosis of pancreatic cancer is poor. Although its incidence is low, pancreatic cancer is the third most common cause of cancer death in the US. Because of the increasing incidence of pancreatic cancer, along with improvements in early detection and treatment of other types of cancer, it is estimated that pancreatic cancer may soon become the second-leading cause of cancer death.

The USPSTF recently updated its 2004 recommendation on screening for pancreatic cancer, reviewing the evidence on the benefits and harms of screening for pancreatic cancer, the diagnostic accuracy of screening tests for pancreatic cancer, and the benefits and harms of treatment of screen-detected or asymptomatic pancreatic cancer.

Recommendation: The USPSTF recommends against screening for pancreatic cancer in asymptomatic adults (**D** recommendation). This reaffirms its previous conclusion that the potential benefits of screening for pancreatic cancer in asymptomatic adults do not outweigh the potential harms.

It should be noted that this recommendation does not apply to persons at high risk of pancreatic cancer due to an inherited genetic syndrome (eg, Peutz-Jeghers syndrome, hereditary pancreatitis) or due to a history of familial pancreatic cancer. Other factors such as new-onset diabetes, preexisting diabetes, older age, cigarette smoking, obesity, or a history of chronic pancreatitis increase risk to a lesser degree. The USPSTF considers asymptomatic persons who have these other risk factors part of the general population, and they are included in this recommendation.

My Comment:

Repeat after me: “Just because we can do a study doesn’t mean we should do a study.” I continue to appreciate the deliberate approach and thoughtfulness of the

USPSTF recommendations. Interesting that just last week I had a patient ask about this very thing, because a friend was diagnosed with pancreatic CA. I smiled and said, “I’m sorry to hear about your friend. Let’s talk about how we can help you stop smoking ...”

References:

- USPSTF Screening for Pancreatic Cancer - August 2019: [Link](#)
 - Owens DK, et al. Screening for Pancreatic Cancer: USPSTF Reaffirmation Recommendation Statement. JAMA. 2019 Aug 6;322(5):438-444. [Article](#)
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From the Literature and Consciousness Raising

3) Microaggressions in Health Care – Part 1: Defining the Problem

The word *microaggression* was initially coined by Harvard psychiatrist Chester Pierce in 1970 and referred to minor yet damaging humiliations and indignities experienced specifically by African Americans. The modern definition of microaggressions describes them as “subtle snubs, slights, and insults directed towards minorities, as well as to women and other historically stigmatized groups, that implicitly communicate or at least engender hostility.” This definition extends beyond verbal abuse to include general disrespect, devaluation, and the exclusion of recipients. Microaggressions occur daily and are commonly delivered automatically with dismissive body language/tone of voice.

As health care organizations continue to value diversity and inclusion among the health care workforce, it is increasingly important to be aware of the obstacles to success for all, but in particular for women and under-represented minorities (URMs). Although the precise science of microaggressions is still being understood, one thing that seems clear from the literature is that microaggressions have a negative effect on recipients.

There are 4 subtypes of microaggressions described: microassaults, microinsults, microinvalidations, and environmental microaggressions.

Microassaults are what one thinks of as “old-fashioned” discriminatory statements. These are often intentional and are the most blatant of microaggressions, characterized by verbal or nonverbal attacks clearly intended to offend the recipient. Examples include comments such as, “You people are all the same, claiming your minority status to take the spots that belong to someone else,” or, “They are letting women be doctors now?” Additional examples include a refusal to work with a woman or URM team member, discouraging interracial relations, and suggesting that women and URMs are not competent physicians or other healthcare workers.

Microinsults are subtle snubs or humiliations that convey a demeaning message to the recipient in a way that may be unintentional to the perpetrator. In medicine, this happens when women or URM physicians are confused for a nurse, janitor, interpreter, or another nonmedical role because they do not fit the traditional image of a physician.

Microinvalidations are aimed to exclude, negate, and dismiss the personal thoughts, feelings, or experiential reality of a person. Microinvalidations are also reflected in the myth of meritocracy, which is the belief that hard work pays off and that race or gender play no role in determining a person’s success. Additional examples include invalidating a woman’s or URM’s experience of inequality by calling them oversensitive.

Environmental microaggressions occur when microassaults, microinsults, and microinvalidations are reflected in the culture, processes, and climate of the workplace. Examples of environmental microaggressions include the lack of child care or proper rooms for breastfeeding mothers at national conferences and within hospitals which perpetuate an unwelcoming environment for families and in particular female physicians. Another example would be the inequitable application of promotion criteria resulting in an exceptionally qualified female or URM faculty member not being promoted on administrative grounds that have never been applied to a male colleague.

Microaggressions extract a psychological and physical toll on those who experience them, as well as a societal price in healthcare of harming the already fragile pipeline of female and minority physicians and other clinicians.

My Comment:

I chose to highlight this article with the intention of raising both individual and group awareness because this concept is becoming more prominent in not just the mainstream literature, but also in the medical literature, as demonstrated by this referenced article out of the surgical literature.

It is important to understand that microaggressions do not happen exclusively to women or URM, but can occur in any interaction between two people in the context of “power dynamics.” The elderly and disabled are other groups for which I observe these occurring regularly. Criticism of the concept of microaggressions includes the fact that defining them based on the recipient’s experience and perception makes them subjective. What may be perceived as a microaggression to one person may not seem like one to another. Additionally, by referring to those who commit microaggressions as perpetrators - a common term in the microaggression literature - they may be perpetuating the idea that these individuals are somehow malicious in intent.

Ultimately, microaggressions may impact care team dynamics and patient care by causing or perpetuating psychological distress or eroding trust. If one is left wondering whether a particular comment was meant to be an insult or not, or whether a patient or colleague doubts our ability, it is difficult to focus on making a diagnosis and identifying the optimal treatment plan. For that reason alone, becoming more conscious of and sensitive to these in our own workplace becomes vital.

In next week’s Take 3, I’ll examine constructive approaches to addressing microaggressions, and how we can all help contribute to a psychologically healthier work culture.

Reference:

Torres M, et al. Recognizing and Reacting to Microaggressions in Medicine and Surgery. JAMA Surg. Published online July 10, 2019. [Article](#)

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

Mark

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