Take 3 – Practical Practice Pointers© September 9, 2019 Edition

Pancreatitis Testing, Racism in Healthcare, Wearable Tech and Health

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From the Guidelines, Choosing Wisely, and Wise Colleagues

1) Testing for Pancreatitis – Time to "Retire" the Serum Amylase

In the US, acute pancreatitis (AP) it is one of the most common gastroenterology discharge diagnoses with an annual cost in the billions of dollars. Despite changes in guidelines regarding the use of blood chemistry to assist with the diagnosis of AP, data would indicate that clinical practice has not uniformly adapted to these changes.

In 2013, the American College of Gastroenterology guideline for the diagnosis and management of AP states the following: *"Because of limitations in sensitivity, specificity, and positive and negative predictive value, serum amylase alone cannot be used reliably for the diagnosis of AP and serum lipase is preferred."*

In September of 2016, the American Society for Clinical Pathology released the following as part of their Choosing Wisely recommendation:

"Do not test for amylase in cases of suspected acute pancreatitis. Instead, test for lipase. *Serum lipase is now the preferred test due to its improved sensitivity, particularly in alcohol-induced pancreatitis. Current guidelines and recommendations indicate that lipase should be preferred over total and pancreatic amylase for the initial diagnosis of acute pancreatitis and that the assessment should not be repeated over time to monitor disease prognosis. Repeat testing should be considered only when the patient has signs and symptoms of persisting pancreatic or peripancreatic inflammation, blockage of the pancreatic duct or development of a pseudocyst."*

My Comment:
This provides a wonderful example of how clinical data can be used to help change clinical practice. A recent quality chart review in our organization revealed that, though not recommended by current guidelines and considered a low-value test, serum amylase was still commonly ordered, with great variation across practices. Based on this, a recommendation has been made to remove serum amylase as an orderable test in our electronic health record. This will provide an extra step (and hopefully, a "nudge") for anyone when they fall into the old habit of trying to order a serum amylase for a patient whom they suspect may have AP. My thanks to one of our Carilion General Internal Medicine colleagues and physician extraordinaire, Jon Sweet, MD, for his work in helping all of us provide better "laboratory stewardship."

References:

- Choosing Wisely/American Society for Clinical Pathology September 2016: Link
- Tenner S, et al. American College of Gastroenterology Guideline: Management of Acute Pancreatitis. Am J Gastro: September 2013;108(9): 1400-1415. Guideline

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From the Literature and a Question from a Colleague

2) Dealing with Racism in Clinical Care

Question:
"How do I care for patients who are clearly racist or otherwise discriminatory? What if they refuse to see a partner or decline a referral because of their prejudice?

Answer:
Competent patients have the right to refuse medical care, including treatment provided by an unwanted physician. This right is granted by informed-consent rules and common law that protects patients from battery. Physicians and other health care workers have employment rights that must be balanced with patients' rights. Employees of health care institutions have the right to a workplace free from discrimination based on race, color, religion, sex, and national origin, according to Title VII of the 1964 Civil Rights Act.

Organizations that make race-based staffing decisions or compel employees to accede to a patient's request for reassignment on the basis of a worker's race or ethnic background may violate Title VII. Nurses and nursing assistants have successfully sued employers who require employees to accommodate such demands by patients. Physicians, however, have not brought such lawsuits.

Beyond these general legal rules, when patients reject physicians on the basis of their race or ethnic background, there is little guidance for health care organizations and physicians regarding ways of effectively balancing patients' interests, employee's rights, and the duty to treat. The authors of this commentary believe that sound decision making in this context will turn on five ethical and practical factors: the patient's medical condition, their decision-making capacity, options for responding to the request, reasons for the request, and effect on the clinician (see flow chart in article). They believe it is helpful for clinicians to consider these factors as they engage in negotiation, persuasion, and (sometimes) accommodation within the practical realities of providing effective care.

The assigned clinician's options for responding include establishing mutually acceptable expectations and conditions for providing the patient with the care he or she needs and is seeking. If other clinicians are available, it is reasonable for those involved to decide among themselves to assign the patient to another, within the practical constraints of providing appropriate care for other patients. **Regardless of the approach taken, patients should be informed that hateful or racist speech is not toerated.**

It is also important to consider that the reasoning behind a patient's request for reassignment may be clinically and ethically important. Requests for an ethnically or a racially concordant physician may be ethically appropriate in certain cases — for instance, for reasons of religion or culture or of language. Patients may request concordant clinicians because of a history of discrimination or other negative experiences with the health care system. Distinguishing such requests from those in which an assigned physician is rejected on the basis of race or ethnic background is usually straightforward. Accommodation in these cases is justifiable.

In contrast, rejection of a clinician that is motivated by bigotry is less deserving of accommodation. Such refusals are generally directed at clinicians who are members of racial or ethnic minority groups that have historically suffered discrimination. Still, in some rare cases, refusal of a physician may be reasonable or worth accommodating —

if, for example, the patient has had a very negative personal experience with people of a particular race or ethnic group.

The final consideration is the effect on the physician or other healthcare worker. For many minority health care workers, expressions of patients' racial preferences are painful and degrading indignities, which cumulatively contribute to moral distress and burnout. Clinicians must balance several ethical obligations. They should respect patients' informed refusals of medical care. They should also subordinate their self-interest to a patient's best interests and overcome any aversions they may have toward patients. Still, no ethical duty is absolute, and reasonable limits may be placed on unacceptable patient conduct.

The authors conclude that patients who demand accommodation for racial biases present health care providers with a difficult conflict involving their professional obligation to provide nondiscriminatory care, their sense of social justice and personal integrity, and their ethical obligations to respect patients' autonomy and medical best interests. For individual physicians the decision to accommodate may be sound when the accommodating physician is comfortable with the decision, employment rights are protected, and the decision does not compromise good medical care.

My Comment:
I reached out to Laura Daniels, PhD, who is a clinical psychologist and one of our Associate Residency Program Directors, for her insights as to how one might respond effectively to overt bigotry on the part of a patient. She answered, "*In short, the issue should be dealt with openly with a direct and compassionate communication style. The response should be compassionate, respectful, and assertive: include the facts, how it affects you/makes you feel, and your request for the patient with regard to changing his/her behavior. Avoid language that could be triggering for a patient."*

If you find yourself having an emotional reaction, it may be important to take a pause, step out for a minute, take a deep breath, finish the bulk of the encounter and then revisit the issue after your mind and heart had some time process . One may say "Earlier you mentioned you had specific preferences for a doctor/nurse based on race. I appreciate that you feel safe/comfortable enough to share your beliefs with me. I have to be honest with you that I find those comments to be offensive. We do not, can not, tolerate such language that is overtly offensive about someone's race (or other characterization). We practice having respectful communication here with one another. This is critical to being able to best care for you. So in the future, please use more respectful language when talking with me or anyone on my team/staff."

In the context of a referral, you might say, "I hear that you do not want to see a doctor/nurse who is X (religion, race, etc), however I am referring you to my colleague because I respect their ability and clinical judgment. The clinicians on this list are the options I feel very confident in giving you. It is ultimately your decision who you choose to seek medical care from and I will respect your decision."

Reference:
Paul-Emile K, et al. Perspective: Dealing with Racist Patients. N Engl J Med February 25, 2016: 374 (7): 708-711. Commentary

From the Literature

3) Wearable Devices and Health

Digital health care technology is evolving rapidly. With the rise of the obesity epidemic, wearable devices have become a standard behavioral intervention. They are used to track physical activity and promote an active lifestyle for those with an alerting system. A systematic review concluded that people using wearable devices improved their amount of physical activity and the number of daily steps regardless of age, sex, and health status.

These devices have been promoted not just for increasing activity, but also for weight loss and chronic disease outcomes like lowering blood pressure, cholesterol, and blood glucose, though their actual effectiveness on these outcomes is not well established. Therefore, the aim of this systematic review was to summarize the evidence from trials of the use of wearable devices on chronic disease out comes among adults.

Articles that were included were randomized controlled trials or quasi-experimental studies with health outcomes published in English up to October 2018. Of a total of 550 publications extracted, 6 studies met the final criteria. The authors concluded:

- Wearable devices play a role as a facilitator in motivating and accelerating physical activity, and ultimately, may contribute to improving clinical outcomes.
- There is no evidence of an effect of wearable devices alone without feedback on reducing blood glucose level, blood pressure, and cholesterol levels.
- The use of wearable devices alone was not associated with weight loss.
- These devices may act as an enhanced lifestyle intervention to prevent chronic diseases.
- These devices provide important feedback to motivate and engage people for healthy outcomes.

My Comment:
This is a great example of where the adoption of a technology has preceded the evidence of effectiveness. Whether this is a result of people "voting with their dollar" for something of value or the "crowd effect" is unknown based on present studies. As I have shared previously, I gave such a device a try and did not find it personally helpful (though it exposed an OCD part of myself that was worrisome ...), but am certainly supportive for those who do. As we study the use of these devices more, and as the technology advances, we'll likely find specific circumstances in which the can serve as tools to help advance health. But as of yet, we just don't know.

Reference:
Jo A et al. There a Benefit to Patients Using Wearable Devices Such as Fitbit or Health Apps on Mobiles? A Systematic Review. Am J Med. 2019 Jul 11. Article

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

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