

Communication as Prevention: The Value of Talking With Each Other

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This issue of the journal has 3 articles that emphasize the value of communication in preventing adverse outcomes for patients and communities. As physicians, we have to talk both with our patients about future issues that will affect their health and with each other about the patients we share. Sadly, these articles also remind us of the potential consequences from a lack of communication.

I remember a patient who, in response to my question about why he had come, said, “I turned 40 this month and I guess there are some things I should get checked.” While there are few differences in the recommendations from the US Preventive Services Task Force at 40 than for the decade before and the decade after, I took the opportunity to ask my patient whether he and his wife had a will, and if they had talked about and made decisions about advance directives. His belief was that such things were for old people. I responded that he was older now than a month ago, that the burden of a sudden devastating illness in a young person fell on his family, and that it was the responsible person who would have something in place to guide them. The next time I saw him, he had it done.

The exploratory study by Sharma and colleagues bravely looks at whether we physicians practice what we preach and sadly, to no one’s surprise, we don’t.¹ Even at Gundersen Health System, which with Mayo Health System has helped La Crosse become a national model for end-of-life care, less than half of the faculty at their community cancer center had advance directives. Even with its low response rate, their

survey of US oncologists raises issues that must be addressed. While the respondents who were older had the documents, less than 40% of those who had them had discussed them with their personal physicians. No data were gathered about whether they had a primary care clinician and, if they did, whether that physician inquired about end-

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of-life documents. If we as doctors don’t ask our patients, we have to take a great deal of responsibility for the low prevalence of such documents in our communities. When we are sitting with families and patients deciding such issues after they arise—as they always do—“don’t ask, don’t tell” is a strategy that will lead to the kind of tragedies all of us have experienced. Both Wisconsin and Minnesota have taken strides toward supporting work in end-of-life care, both our patients’ and our own, with the Wisconsin Medical Society building on previous programs through its Honoring Choices Wisconsin program,² but there is much work to be done in this area.

It is redundant to say that falls are an increasing source of morbidity and mortality in this country as we see larger numbers of us age into the balance- and strength-challenged generation.³ And larger numbers of us will end up spending part of our lives

in nursing homes. So decreasing the potential for falling in nursing homes is a very big deal. Chapman and Newenhouse’s survey of nursing home staff and administrators in largely rural institutions found that communication among staff about changes in a patient’s condition was the largest modifiable variable that could influence the rate of falls.⁴ Doctors who care

for nursing home patients must sit with lead nurses and staff to talk about patients, with a particular attention to falls potential. And nursing home staff should talk with each other for the same reason. While physicians and patient care staff huddling together prior to a clinic session or hospital rounds seems to be a logical way to plan the day, it rarely happened until recent increased emphasis on medical home and patient-centered care prescribed it as one of the essential components for the process. Chapman and Newenhouse also point out what many urban clinicians may not know, which is that falls are a greater risk in a rural population than urban nursing home populations. Their findings should challenge hospital systems that work with rural nursing homes to provide ongoing education, assistance, and support for the in-facility and between-facility challenges for falls prevention.

The encouraging data from the article by

Layde and Remington⁵ on the decade long decrease in teen pregnancies in Wisconsin are tempered somewhat by the continued, although narrowing, discrepancies between white and black populations and by the distressing data on increases in the American Indian and Latino populations. While the authors were able to describe only county and state trends, the discussion in this paper highlights a community and public health research agenda that would help identify effective methods for decreasing teen pregnancies. One can hope that the increased conversations at school, social centers, and in families about encouraging teens to use contraceptive methods to avoid pregnancy and take responsibility for themselves and others has had some effect on these trends. Physicians can offer guidance and advice and birth control—not inconsequential components of a program of prevention. What also is needed however, as the authors point out, is continuity conversations among teens, teachers, parents, and the community at

large about attitudes and behaviors that might help young people be parents when they are better able to fulfill that role.

Two case reports highlight the vulnerability of kidneys to unexpected adverse effects. Dabigatran is a popular newer agent for prevention of the thrombotic consequences of surgical and cardiac illnesses but, like many new agents each year, can have unintended serious consequences that are not widely known. Shafi and colleagues⁶ do a service for us all through their reporting of a case of acute renal failure that should alert others who prescribe dabigatran. Murphy and colleagues report a case⁷ of biopsy proven tubular injury and Fanconi syndrome likely caused by deferasirox, which is an agent primarily used in iron-overload syndromes where phlebotomy is not an option. Although the patient they describe had a number of serious ongoing medical problems relating to cancer care, the case reminds us to think first of medications as a potential cause of deterioration, since this is something we can

change and potentially reverse the problem, which it did in this case.

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