



A newsletter for the physicians of Tampa General Hospital

Should Doctors Sit or Stand?

By Julie Deardorff—(Reprinted , with permission, from The Chicago Tribune/Julie Deardorff)

Doctors who sit down on the job are perceived as spending more time with patients than physicians who stand, according to a pilot study conducted at the University of Kansas Hospital. But in reality, sitting doctors, actually spend *less* time with patients than standing ones, the study found.

Medical students are often taught that sitting with a patient will make it seem like they're in the room longer, said lead author Paul Arnold, director of the University of Kansas Hospital's Spinal Cord Injury Center. But there isn't much evidence backing up the claim.

To test it, Arnold divided 120 of his post-operative patients in two groups of 60. Half the time, he'd walk into a room and sit down. The other times, he'd stand.

The researchers found that Arnold's standing visits lasted an average of 1 minute, 28 seconds. The patients, meanwhile, thought the appointment lasted an average of 3:44.

When Arnold sat down, the average time spent seated was just over one minute, which was actually shorter than when he stood. But the patients thought he spent more than five minutes in the room.

Overall, patients thought Arnold spent 40 percent more time in the room when he sat down. When 38 of the patients were questioned about their interaction, the ones who saw the seated doctor "expressed greater satisfaction and a better sense of understanding of their condition," than those who saw the standing doc, according to the study.

"In most hospitals, physicians want to get in and out of the room and often there's no good place to sit," he said. "But I received uniformly positive responses when I'd sit down. When I stood, people thought they were being rushed or didn't get questions answered."

Dr. Lanny Wilson always sits down after he welcomes a patient. "Even if she's been my patient for years, allowing time for her to get comfortable in that vulnerable setting is crucial," said Wilson, an ob-gyn at Adventist Hinsdale Hospital. "Sitting down and looking a patient in the eye makes her feel secure and re-establishes trust, which is so crucial to the doctor-patient relationship. It's about connecting with your patients as individual people.

Lombard physician David Rivera, who shuns both a white coat and tie, agrees. He routinely sits because he doesn't want to intimidate the patient. In a hospital, he'll sit on the bed or even kneel on the floor if the bed is too low.

"I sit down, look at the 'reason for visit' in the chart, then put the chart aside and ask, 'What can I do for you today?'" he said. "Patients will tell me what I need to know without conducting an inquisition." But there's another reason: "I'm six feet tall and I have chronic back pain," he said. "Why stand when you can sit?"



Outcomes In Perspective Going Green!

This will be the final issue of Outcomes In Perspective published in the paper format. The July issue will be electronic and accessible on the TGH website. A Monthly e-mail with a direct hyperlink to the most current issue will be sent to the physician staff. An additional hyperlink will access the previous 12 months of Outcomes In Perspective. We hope you will continue to enjoy the newsletter in its new electronic format.

Goal Directed Therapy for ICU Sedation: The Richmond Agitation Sedation Scale (RASS)

Maresa Glass, PharmD, BCPS—Critical Care Pharmacotherapy Specialist

The clinical practice guidelines from the Society of Critical Care Medicine for the sustained use of sedatives and analgesics in the critically ill adult emphasize the need for goal-directed delivery to avoid oversedation and to promote earlier extubation. Most available evidence regarding sedatives and analgesics in ICU patients highlights the need for proper titration using goal-directed delivery to optimize patient comfort while avoiding complications such as prolonged mechanical ventilation or reintubation.

This “goal-directed delivery” of sedatives is best accomplished by the use of sedation scales to help the interdisciplinary team agree on a target sedation level for each individual patient. Sedation scales with broad acceptance include the Ramsay scale, the *Sedation Agitation Scale (SAS)*, the Motor Activity Assessment Scale (MAAS), the COMFORT scale for pediatric patients, and the *Richmond Agitation-Sedation Scale (RASS)*.

Starting June 1, 2010, Tampa General Hospital will use the Richmond Agitation Sedation Scale (RASS) to monitor sustained sedation in all ICU patients.

A unique feature of RASS is that it uses the duration of eye contact following verbal stimulation as the principal means of titrating sedation. RASS has been demonstrated to have excellent interrater reliability and to have excellent validity when compared to a visual analogue scale and selected sedation scales.

Richmond Agitation Sedation Scale (RASS)		
Score	Term	Description
+4	Combative	Overtly combative, violent, immediate danger to staff
+3	Very Agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressive or vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to <i>voice (>10 seconds)</i>
-2	Light Sedation	Briefly awakens with eye contact to <i>voice (<10 seconds)</i>
-3	Moderate Sedation	Movement or eye opening to <i>voice (but no eye contact)</i>
-4	Deep Sedation	No response to voice, but movement or eye opening to <i>physical</i> stimulation
-5	Unarousable	No response to <i>voice or physical</i> stimulation

(References for above article available from the author)



SAVE THE DAY!

*The Medical Staff 2010 Annual Meeting
Will be held Wednesday, September 22nd*

At the Weston Harbor Island Hotel beginning at 6:00 pm.

Headlining the meeting will be:

Voting for Medical Staff Officers and Medical Staff Recognition!

MARK YOUR CALENDAR NOW!



TGH Pharmacy & Therapeutics (P & T) Committee UPDATE: March 2010

John Allen, PharmD, PGY1 Pharmacy Resident

**Please visit Micromedex – FORMULARY ADVISOR for more details of the latest formulary decisions and access to the TGH Formulary. Micromedex – FORMULARY ADVISOR is available on any computer in the hospital with an internet browser!*

Protein Supplement Guidelines (Proteinex®, Beneprotein®)



Protein supplement guidelines were presented by dietary services and reviewed by the committee. A comparison of Proteinex and Beneprotein was discussed. Proteinex is a more concentrated supplement and less likely to clog feeding tubes. Proteinex will be dispensed by pharmacy as a 18g/30mL solution and will be used in adult patients only. Beneprotein powder will be used for adults and pediatric patients and will be distributed by dietary services. Beneprotein is a powder and requires 120mL of water to deliver 6g. The powder will continue to be used for burn milkshakes, smoothies, and pedi diet. The P & T Committee reviewed the plan with further details to be discussed in the April meeting.

Daptomycin (Cubicin®) follow up

Efforts are ongoing to eliminate daptomycin surgical prophylaxis in non-infected patients. These efforts include removal of daptomycin from pre-printed pre-operative and post-operative order sets. A prospective analysis is also being performed on all pre-operative daptomycin orders. Data on 100% of daptomycin orders in operative settings will be presented to the P & T Committee for follow-up.

Factor IX Complex (Prothrombin Complex Concentrate)

Factor IX Complex is a mixture of vitamin K-dependent clotting factors II, VII, IX, and X. These factors are required for the conversion of prothrombin to thrombin and for adequate hemostasis. A similar agent is recombinant Factor VII (Novoseven), currently on TGH formulary (guidelines available on Micromedex Formulary Advisor). Factor IX Complex is FDA approved for the prevention and control of bleeding in patients with Factor IX deficiency due to Hemophilia B. The P & T Committee did not add Factor IX Complex to the TGH formulary due to a lack of controlled trials and establishment of a clear role compared to recombinant Factor VII (Novoseven).

Dexlansoprazole (Kapidex®)

The proton pump inhibitor class was reviewed along with the newest agents to the class, dexlansoprazole (Kapidex). Dexlansoprazole has dual profile characterized by an immediate release action followed by a delayed second peak. No differences have been noted within the class once patients reach steady state. The P & T Committee did not add dexlansoprazole to formulary due to a lack of differences noted at steady state and lack of outcomes data showing a difference compared with currently available proton pump inhibitors. An automatic therapeutic interchange to the formulary agent of choice pantoprazole (Protonix), orally, and lansoprazole (Prevacid), per tube, was also approved.

MMR therapeutic interchange for Rubella

A report was presented to the P & T Committee related to the shortage of Rubella vaccine and the need to switch to Measles, Mumps, and Rubella (MMR). The P & T Committee approved an automatic therapeutic interchange to MMR from Rubella vaccine during the shortage with the provision of a medication information sheet to the patient, alerting them of the interchange.

Multivitamin (MVI), folate and thiamine injection, IV to PO conversion

Multivitamin (MVI), folate, and thiamine injections have been in shortage at TGH. The Committee approved an automatic IV to PO conversion of MVI, folate, and thiamine for patients with functional GI tracts who are already receiving oral or enteral medications.

Pharmaceutical Shortage Update:

Additional shortage information is listed on Micromedex Formulary Advisor and updated as necessary.



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Quality Improvement Department

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WE'RE ON THE WEB
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TGH Welcomes our new Physicians



The physicians below were added to TGH staff: 3/31 & 4/30/2010

Larry Fishman, MD
Lukasz Janeczek, MD
Daniel R. Marin, MD
Abu S. Mohammad, MD
Daniel D. Cabello, MD
Guillermo O. Castellvi, MD
Samuel A. Joseph, MD
Mario R. Lopez, MD
Anthony P. Moreno, MD
Nilesh J. Patel, MD
Marela Z. Velez, MD

Neurological Surgery
Family Practice
Physical Medicine & Rehabilitation
Internal Medicine/Hospital Medicine
Neurology
Surgery/General Surgery
Orthopaedic Surgery
Internal Medicine/Hospital Medicine
Orthopaedic Surgery
Anesthesiology
Internal Medicine/Infectious Diseases

KUDOS TO OUR PHYSICIANS!

Congratulations to the following physicians who were recognized by their patients in the form of personal letters to TGH leadership.



**Dr. Narendra Sastry (2), Dr. Mark Rofle, Dr. Cedric Sheffield,
Dr. Tarik Haddad, Dr. Christiano Caldeira, Dr. David Solomon,
Dr. Robert Geck, Dr. Grace Dongan and Dr. Nicole Mead**

This newsletter is produced by Tampa General Hospital's Quality Improvement Department. All comments, responses or suggestions are welcome and should be directed to:

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