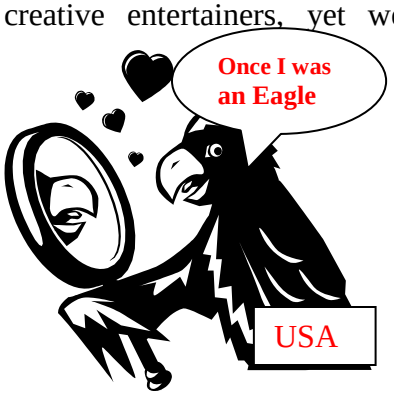
Patient Safety America Newsletter

April 2013 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: How many times more likely is an American to die of gun violence than people living in other developed countries? A) 2 b) 10 c) 20 d) 100 e) 200*

Mirror, Mirror on the Wall – Why Are We the Poorest of All?

We Americans are surrounded by things that fill us with national pride about what it means to be American. We produce powerful Olympians, brave military heroes, brilliant Nobel Prize winners, and creative entertainers, yet we continue to spend inordinate amounts of money on a broken healthcare industry that delivers last-place results, at least among other major developed nations. A recent report from the National Research Council and Institute of Medicine documents our health disadvantage and asks how so many other countries can get it right, but we just cannot seem to catch up.[1]



There are key indicators that suggest why we perform poorly: we lack universal health coverage, our medical care is more focused on specialty care than primary care, access to care is more challenging for many people, and care is more often uncoordinated. To this one can add the following: American teenagers engage in more risky behaviors (e.g. less likely to practice safe sex), we have a high poverty rate, we consume more calories per person, we have more guns than anyone else, and our educational system is falling behind other prosperous states.

The result of all this is that that we have the lowest life expectancy, the highest infant mortality rate, the highest obesity rate in adults, the highest prevalence of diabetes, the highest rate of drug related deaths, and the highest gun homicide rate. The good news: If you manage to live 75 years as an American, your life expectancy is comparable to that in other developed countries.

In my opinion, we can keep our heads buried in the sand and pretend that this is still the greatest country in the world, but it isn't. When you can't nurture and educate the little children in your country and you continue to trap an inordinate portion of your people in poverty, then you are a second-class nation.

Dangers of Sleeping Pills

The FDA has just issued a warning about driving the day after use of the sleeping aid zolpidem, and then commented that sleeping aids in general can leave their users drowsy the next morning.[2] About 1 in 7 women and 1 in 30 men had blood levels of zolpidem that could impair driving ability 8 hours after taking the usual dose (10 mg). Be wary of the extended-release form of this drug (12.5 mg). One third of women and one fourth of men had blood levels associated with potential

driving impairment 8 hours after taking this form of the drug. The risk may be somewhat higher in elderly patients. If you are taking this stuff, ask your doctor if a lower dose might be better to use. Better yet, figure out why you are having trouble sleeping.

Healthcare on Demand – or not

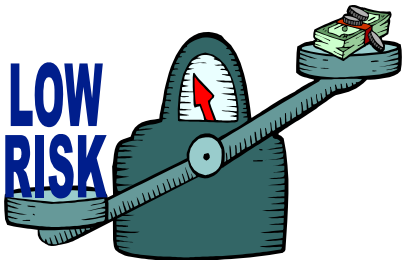
Sometimes half-way solutions can be worse than no solution at all. For example, let's suppose that you want your teenage driver to learn to take care of his car, so you declare that he is responsible for the cost of any repairs. Sometime later it is clear to him that he has a problem with his car, but he does not have the money to afford repairs, so he just keeps driving. One day the car totally breaks down and has to be towed to a repair shop for what are now very expensive repairs – you must pay for! In discussing why this happened with your son, you realize that your good intentions had an unintended consequence – your son would ignore the need for repairs until the car totally failed. Well, at least in our story, the car was repairable. It could have been worse. Your son might have suffered a serious, injurious accident because his car was in disrepair.

Hopefully this analogy helps you understand what has happened in response to the Emergency Medical Treatment and Active Labor Act of 1986. Realizing that our society as a whole has an obligation to provide at least basic medical care even to those who cannot pay, this act was intended by Congress to fill that obligation. It has had two regrettable consequences. First, like our young driver above, folks without money to pay for preventive care or care of minor health problems, wait until they are in a dire condition to show up at the emergency room for very expensive care. Another unintended consequence is that politicians have mollified their uninformed consciences by declaring that the poor are covered because all they have to do is show up at an emergency room for medical care (President Bush and Governor Perry).

Three MDs expressing their views in the *JAMA*, note that the Affordable Care Act continues with the Emergency Medical Treatment and Active Labor Act, and adds provisions emphasizing preventive care, but any provisions to motivate people to take advantage of preventive care are weak at best.[3] Furthermore, there is no plan to integrate primary care and emergency room (ER) care, nor is there a plan to help pay for ER visits for those who cannot pay. The writers clearly envision the need for more reforms to facilitate access to care for all. In the meantime, it seems to me that expansion of Medicaid to more poor folks is a reasonable, interim solution. But this is not the ultimate solution.

Mismanagement of Health Risks

Most of us understand that safe operation of a vehicle depends on it having good tires. So, do you change your tires every 10,000 miles just to be sure your tires are really, really super safe? If you do, then please do not read on; you are a lost cause. But, if you seek care in the American medical system, you may be sold the equivalent of new tires when your "old" ones are still safe. An MD writing in the *JAMA Internal Medicine* describes how he has been sold low-value medical care.[4]



A visit to an optometrist detected pallor in the doctor's optic disc, but he had no symptoms. He chose not to follow up with an ophthalmologist as recommended by his optometrist, and a year later a second examination showed no progression of the "condition." None the less, his optometrist encouraged him again to visit an ophthalmologist. When the patient/doctor did that, the ophthalmologist recommended a series of 3 tests 'just to be sure.' The ophthalmologist used a pinch of what I would call the "fear factor." He wanted to use the tests to rule out multiple sclerosis, neurovascular disease, a tumor on the 4th cranial nerve and thyroid disease.[4]

After the first test, which was an MRI showing no abnormalities, the patient/doctor decided that this was enough and declined the other two tests. On hind sight, the doctor-turned-patient said all he wanted was some new glasses and reassurance that almost certainly nothing sinister was going on in his body. He felt that he had not received patient-centered care. One thing I liked about the viewpoint of the doctor was that he felt that the public, starting in high school, needs better education about how to find and use evidence-based, patient-centered medical care.

There are two warnings in this story for patients. The first is not to be drawn-in by fear as this physician was. Secondly, think and ask questions until you fully understand the need for any expensive procedure. It's your money.

Fitness and Dementia

I just returned from running my requisite 3-miles, which I did in the gritty, afternoon heat of downtown San Antonio. It was not fun. Sometimes I wonder what impels me to do this when I could have been tossing down a beer or reading my emails. Occasionally, I come across a study that helps me get out there when my body is telling me that running can wait.

This month I came across a study in the *Annals of Internal Medicine* showing that midlife cardiorespiratory fitness is associated with a reduced risk of all-cause dementia later in life.[5] The study involved almost 20,000 adults that had undergone a treadmill test between 1971 and 2009. A little less than 1700 cases of dementia were identified from Medicare records after a median follow up time of 25 years. After the requisite multivariate adjustments, folks in the highest fifth for midlife fitness had roughly 1/3 less chance for dementia than those in the lowest fitness category.

And so I go out in unpleasant conditions and run, knowing that I am well past my midlife years. The fact is, I run because I enjoy the outdoors and feel great when my run is over. Some would say that I have not necessarily avoided dementia – running in the heat is proof of that. I would encourage you to find a fitness activity you enjoy and just maybe you'll be reducing your risk of dementia. I might point out that fitness reduces all-cause mortality even in those who are overweight.[6] Starting a fit lifestyle at a young age is associated with continuing fitness during midlife. Given the fear we all have of Alzheimer disease, perhaps this could be used as a motivator for us couch potatoes to get moving.[6]

Mental Health Fitness

Most of us with moderate-sized families know a member of our clan with mental health illness. Lately the spotlight has been projected on the need for improved mental health services for youth because of the mass killings by young males. Three experts write their views on what needs to be done to improve access to mental health services for young Americans.[7] They point out that in 2008 only 63% of the counties in the U.S. had outpatient mental health facilities for youth. Youth-treatment facilities are especially lacking for those living in rural counties. Furthermore, state funding for mental health services has decreased by $1.6 billion since 2008, suggesting that the situation is getting worse.

The writers suggest several ways to improve mental health services for youth. Some basic services could be provided through school-based programs, but school budgets are being squeezed. The capabilities of primary-care, safety-net facilities could be expanded to meet the need for mental health services, but many more mental health workers are also needed. The stigma associated by parents with seeking mental health treatment for their children needs to be addressed through better education.

It is unclear to me where the money will come from to achieve the suggested improvements. Perhaps we could find a way to reduce the estimated $750 billion of waste that is attributed to our inefficient, money-driven medical care system, and then spend some of that money on improving mental health services for our children. It is a matter of evidence-based priorities and whether we have the courage to reform the American medical industry.

Death by Pharmaceuticals

Three experts analyzed a recent 2010 vital-statistics report based on death certificates. They were looking for deaths caused by overdose of therapeutic drugs.[8] There were 22,000 such deaths of which 74% were unintentional, 17% were suicides and 8% were of unknown intentions. The categories of drugs involved in the deaths were as follows: opioids (75%), benzodiazepines (29%), antidepressants (18%), and anti-parkinsonism drugs (8%). The total is above 100% because many deaths resulted from a combination of drugs. The authors note that 25% of the death certificates did not

disclose the type of drug associated with the cause of death.

It seems to me that we need to go beyond dissecting the kinds of drugs that cause unintentional death to the root causes. Did the drug come from a prescription or an illicit source? If it was available by prescription, was the patient adequately warned of the dangers of overdose? Did the patient have a history of abuse of therapeutic drugs? Did the patient fully understand when to take the drug? Was the overdose a mere accident?

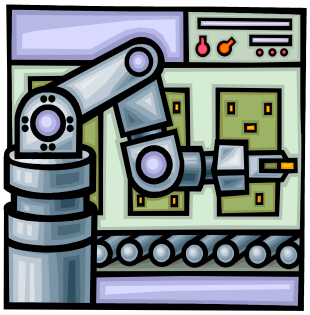
Confidence in Drug Companies?

In an editorial entitled "Restoring confidence in the pharmaceutical industry" two physicians write about the erosion of confidence in this industry and what it needs to do to restore confidence.[9] The public and physicians have lost confidence in the wake of huge fines against major companies for data manipulation and unlawful and unethical marketing practices. I know many folks that are unhappy that some drug they have been taking has been discovered to have serious heart effects years after it was approved for use. It is not just the pharmaceutical industry we do not trust; we do not trust regulators of the pharmaceutical industry.

According to the editorialists, to restore confidence, the industry must allow unbiased, academic medical experts to play key roles in pre-marketing studies, and ***all*** the data from those studies must be made public. Furthermore, drug companies should not do direct-to-consumer advertising until post-marketing studies are completed. In the meantime, I would be wary of taking any drug that has not been on the market at least 3 years.

Robotic Surgery for Hysterectomy

I had robotic surgery in 2008 and thought I was getting the best there was, albeit at an increased cost to my insurance company. No, it was not a hysterectomy. Anyway, in a review of 260,000 cases of American women who had had a hysterectomy from 2007 to 2010, investigators noted an increase in the percentage that were robotically assisted from ½% to 10%.[10] The fact is, there was no advantage in clinical outcomes for the women who received robotic surgery, but the cost was on-average about



$2000 more than for a traditional laparoscopic hysterectomy. Robots for surgery are expensive ($1-2.5 million);[11] however, manufacturers of these machines have engaged in intense marketing campaigns, especially to consumers. The medical writers call for better scrutiny of expensive new technologies that do not offer any advantage to the patient over traditional, less expensive procedures.

As someone who may need a hysterectomy, you should ask hard questions about whether you really need the procedure, and then ask why you need to have it done robotically if that is what is offered to you.

References

1) Woolf SH, Aron LY. The US health disadvantage relative to other high-income countries. JAMA 2013;309:771-772

2) Kuehn BM.FDA warning: Driving may be impaired the morning following sleeping pill use. JAMA 2013;309:6435-646

3) Vickery KD, Sauser K, Davis MM. Policy responses to demand for health care access. JAMA 2013;309:665-666

4) Umscheid CA. Snapshots of low-value medical care. JAMA Intern Med 2013;173:186-187

5) DeFina LF, Willis BL, Radford NB, et al. The association between midlife cardiorespiratory fitness levels and later-life dementia. Ann Intern Med 2013;158:162-168

6) Sano M. Never too fit for body and mind. Ann Intern Med 2013;158:213-214

7) Cummings JR, Wen H, Druss BG. Improving access to mental health services for youth in the United States. JAMA 2103:309:553-554

8) Jones CM, Mack KA, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. JAMA 2013;309:657-659

9) Bauchner H, Fontanarosa PB. Restoring confidence in the pharmaceutical industry. JAMA 2103;309:607-609

10) Weissman JS, Zinner M. Comparative effectiveness research on robotic surgery. JAMA 2013;309:721-722

11) http://www.creators.com/health/david-lipschitz-lifelong-health/robotic-surgery-is-all-the-rage-but-price-is-high.html

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Answer to question this month: c) 20 times more likely (http://tinyurl.com/a4yzn3o)