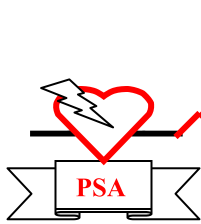


Patient Safety America Newsletter

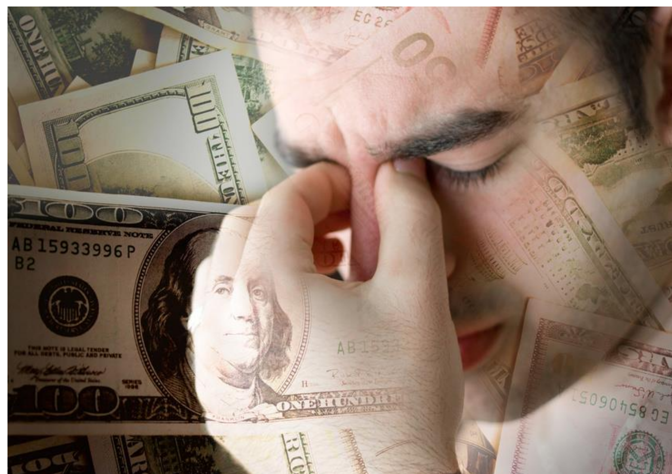
July 2013 http://PatientSafetyAmerica.com *John T. James, Ph.D.*

***Question**: According to a recent report from the Office of Inspector General of the Department of Health and Human Services, how many general-care physicians had questionable prescribing practices in 2009?*
a) 100 b) 700 c) 1000 d) 7,000 e) 10,000

Physician Impairment

I dare say that most of us adults, at one time or another, have gone to work impaired to the point where we are well below our optimal performance level. I recall a time when I worked in a hospital clinical lab and one of the other students working the overnight "Stat Lab" shift went to sleep while holding a blood gas sample in his hand. We found him sitting in a chair with the blood sample still in the ice cup, the machine calibrated, and him totally asleep. There are many reasons for workers to be impaired on their jobs, and physicians are no exception.

A "viewpoint" article in the *JAMA* considers the ways impaired physicians should be identified. The writers, 3 MDs, point out that in *other* high-risk industries individuals involved in a serious adverse event are tested for alcohol and drug impairment. The MDs point out that this does not happen to doctors when an adverse event occurs, yet we know that roughly one third of hospitalized patients experience a medical error. They ask why medicine is much less regulated than other industries, tracing this to the trust embodied in the physician-patient relationship and the concept that this relationship is not the business of government regulation.



They write, however, that patients have a fundamental right to be protected from impaired physicians. Thus there is a need for government regulations and surveillance. I would argue that the existing controls on physician competency and lack of impairment fall far short of protecting patients and that patient safety activists should have a strong role in defining what improved control looks like. The days of the physician community regulating itself must become history – it is not working. The writers advocate a 5-point process, but they overlooked an important method called the 360 review. Under this review process subordinates, colleagues, and supervisors anonymously evaluate the performance of each physician. If a physician is identified as impaired, then there must be a pathway to rehabilitate him. Each one is a valuable resource when ***un***impaired.

Buying your Doctor

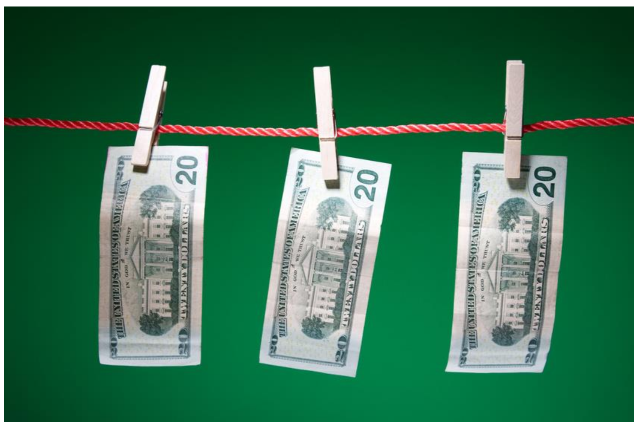
I work for the federal government where the constraints on any gifts I receive are severe. The thinking is that my loyalty must be to the citizens who pay my salary and not to some company or individual trying to get a favor. Likewise in medicine, we patients must hope that our doctor's loyalty is only to us and not to some company that has extended favors to him. Research has shown that even small gifts can induce behavioral changes. A national survey showed that in 2009 about 70% of physicians received gifts.[2] In that same year, Massachusetts implemented a law requiring reporting of gifts of more than $50 in value from drug and device companies. Analysis of the resulting database showed that the most common gift was food and the highest value "gifts" were for bona fide services.[2]

In an associated article entitled “Sunlight as disinfectant – New Rules on Disclosure of Industry Payments to Physicians” two experts describe how the Sunshine Act, which is part of the Affordable Care Act, will require almost all producers of medical stuff to report gifts to physicians or hospitals that amount to more than $10 per gift or $100 per year.[3] In September 2014, the Centers for Medicare and Medicaid Services will post the reported data. The authors postulate that this “sunshine” could alter patients’ trust in their doctor and that doctors may not be quite so inclined to utilize expensive, brand-name products. Unfortunately, past data on provider bias has not often been used by patients; however, insurance companies may use the data in their considerations of physician bias.

Getting Rid of Fee for Service Payments

Most of us have been hit by medical bills that list many charges from physicians for services provided at some time, especially while we were hospitalized. The fee-for-service system is considered the major driver of high healthcare costs in the U.S.[4] This system encourages increased volume, more expensive services, and higher duplication of services. It is well recognized that this system must be replaced by a fixed-payment, value-based system with an emphasis on preventive care instead of piecemeal treating of illness as it occurs. This is according to 2 MDs writing for the National Commission on Physician Payment Reform.[4]

The Commission came up with a dozen discrete recommendations. I was happy to see number 11 on their



list, in which Medicare was encouraged to look for savings by reducing the number of inappropriate uses of medical services. This would be the selling of unneeded procedures to patients and expecting Medicare to pay for them. The writers note that the Congressional Budget Office expects a savings of about 140 billion (per year) by elimination of overutilization. In my opinion, Medicare is going to have to get some smarter watchdogs to clamp down on overutilization. Phasing out of fee-for-service, if it can be done, is going to make their job easier. Four surgeries you should avoid (AARP): http://www.aarp.org/health/conditions-treatments/info-05-2011/4-surgeries-to-avoid.5.html

Quality Measures to Reduce Overuse

Two MDs expressed their views in the *JAMA* on being careful when fabricating measures of overuse.[5] They declared that there should be “strong evidence” that a service is not beneficial to patients before it is a target of overuse measure. Yet they admit that there should be “efforts to control” widely-used services when there is no evidence that the service is beneficial to specific groups of patients. Groups of patients for which the service might be beneficial should be excluded from the denominator of any measure of overuse. For example, annual mammograms for low-risk women aged 40 to 50 is overuse, but it is not overuse for women over age 50.

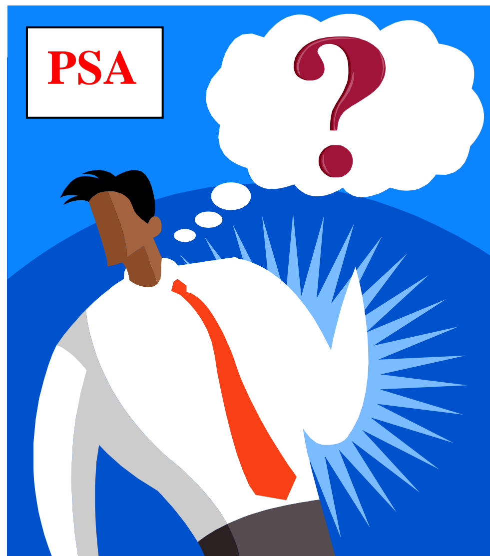
The writers caution that unintended consequences of overuse markers are certainly possible - especially if patients that need a given service are not given that service for fear that it would be considered overuse by the insuring agency or score-keepers. I liked the fact that the writers included patients in the groups that should be involved in developing measures of overuse. There is widespread recognition that patients need to be involved in many more aspects of forming patient-centered care; I’m uncertain where such patients are going to come from. The evidence is often complex and tedious to digest even for experts, let alone non-expert patients.

Regarding overuse, an MD (Dr. Katz) wrote in the “Less is More” section of *JAMA Internal Medicine* an article entitled “Can we stop ordering prostate-specific antigen tests?”[6] This doctor heads a huge safety-net medical care system and is faced with using the funding he has to optimize the care of the patients coming into his system. He summarizes the evidence-based recommendation against any screening using the PSA test because it provides little value, especially for men over 75 years of age.[7] So, he asks, why do such tests continue to be ordered in many systems (including his own), even for men over 75 years of age?

One answer he offers is that many physicians do not agree with the evidence-based recommendation. In

addition, it seems that private insurance companies and Medicare and Medicaid continue to pay for these tests.

Citing other articles in the same journal issue, Dr. Katz shows how harmful PSA screening can be. In a study of 25,000 veterans over 65 years old, with PSA screening values greater than 4 ng/mL, 8,000 underwent a biopsy. Of those biopsied, 500 had complications from the biopsy and 5,000 received a diagnosis of prostate cancer. Of the more than 4,000 men treated for cancer, 600 developed incontinence and 600 developed erectile dysfunction. He notes that this is a lot of harm from a screening test that is not even recommended because there is no evidence of its value to patients.



What we need, Dr. Katz opines, is to inform patients of the risks and benefits of PSA screening, and then ***they*** can decide if they want the PSA screening. He laments the time physicians might have to spend informing patients, but I see this as a non-issue. A carefully prepared video, accepted as balanced by experts and patients, could be shown to men considering the screening test. This has the benefit of removing any bias the individual physician might have for or against screening. The video could be updated as new data emerge.

Last month the American College of Physicians weighed in with its opinion of PSA screening: 1) men between the ages of 50 and 69 should be made aware of the limited potential benefits of PSA screening and the substantial harms of screening, and 2) Men older than 69 or younger than 50 should not receive PSA screening.[8]

Potassium and Nutrition

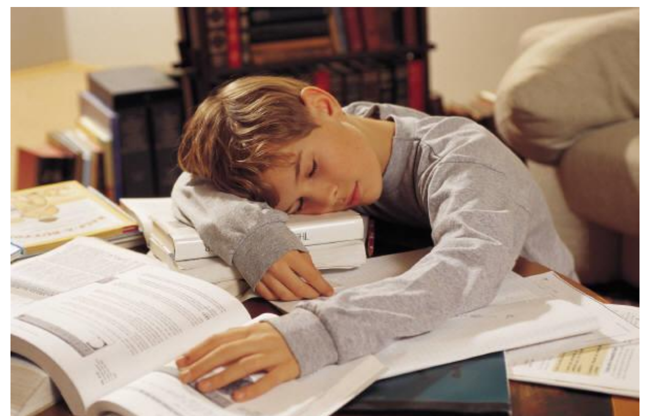
The last email I sent my 19-year old son before he died of untreated potassium depletion was a list of foods I thought he would like that were rich in potassium. He died 3 days later while running on the Baylor University campus. His cardiologists had totally missed the overwhelming evidence that his heart was dangerously at risk because of his potassium (and magnesium) depletion. Potassium depletion, especially when accompanied by magnesium depletion, causes potentially fatal heart arrhythmias and structural damage to the heart.[9]

A cardiologist at a major medical center who read my book about my son's misguided care wrote me that she always thinks of potassium depletion when her patients have heart arrhythmias, and she is frustrated that many of her colleagues overlook this common cause of heart "irritability."

Three experts writing in *JAMA Internal Medicine* lament the lack of potassium content labeling on foods.[10] Of more than 6,500 packaged foods they identified, less than 10% listed potassium content. They challenge those responsible for food labeling to include a requirement for potassium content labeling in the next round of labeling changes. I could not agree more.

Sleep Aid Causes Surge in ER Visits

The sleep aid Zolpidem has just been associated with a 220% increase in ER visits from 2005 to 2010. The basis for this association comes from the Drug Abuse Warning Network (DAWN), which monitors harm and death from drugs taken as prescribed or recommended (http://tinyurl.com/d5shp9u).



This drug can cause side effects of daytime drowsiness, dizziness, hallucinations and sleep-walking. When combined with other drugs such as anti-anxiety drugs or pain relievers, the caliber of the harm increases. Make certain that your doctor knows about all medications you are taking; use drugs like Zolpidem as little as possible. See the side effects of drugs: http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm196029.htm

News on Infant Mortality

In my opinion, one of the key indicators of the worth of a country's healthcare industry is its infant mortality. Infant mortality is the death of a baby before his first birthday. By this measure the United States fails

miserably. In news from the Centers for Disease Control, the U.S. infant mortality, as of 2011, ranked 27th among the 34 nations in the Organization for Economic Cooperation and Development at 6.1 infant deaths per 1000 live births. Alabama and Mississippi were the states with the highest rates at 8 or more infant deaths per 1000 live births in 2010. (http://tinyurl.com/c3kg77e).

Government Intrusion or Protection of Citizens

The news recently has been splashed with stories of the intrusion of the National Security Agency into monitoring of our electronic communications under the guise of protecting our citizens from terrorists. This disclosure happened because a contractor employee released highly classified information, and then he fled our country. No one would disagree that one role of government is to protect its citizens from harm from other groups, but at what cost.

An MD wrote a perspective in the *New England Journal of Medicine* on the role of government in protecting public health, such as by warnings on cigarettes or protecting workers from unsafe conditions.[11] How this is accomplished can be intrusive to some lifestyles. For example, the proposed ban on huge, high-calorie drinks in New York City was offensive to some. Basically, at some point people have the right to make choices that most others consider stupid. The writer concludes that the government has a responsibility to implement public health measures that protect people from harm.

I was seriously disappointed that the writer never mentioned the public health risk of U.S. medical care. Certainly, many people are healed by medical care, but far too many are harmed or killed by medical care that is oriented more to making money for the industry than protecting the public from harm caused by overuse and preventable adverse events.

References

1) Pham JC, Pronovost PJ, Skipper GE. Identification of physician impairment. JAMA. 2013;309:2101-2102
2) Kesselheim AS, Robertson CT, Siri K, et al. Distributions of industry payments to Massachusetts physicians. N Engl J Med 2013;368:2049-2052
3) Rosenthal MB, Mello MM. Sunlight as disinfectant – new rules on disclosure of industry payments to physicians. N Engl J Med 2013;368:2052-2054
4) Schroeder SA, Frist W. Phasing out fee-for-service payment. N Engl J Med 2013;368:2029-2032
5) Mathias JS, Baker DW. Developing quality measures to address overuse. JAMA 2013;309:1897-1898
6) Katz, MH. Can we stop prostate-specific antigen screening tests? JAMA Intern Med 2013;173:847-848
7) US Preventive Task Force. Screening for prostate cancer: Recommendation Statement. Ann Intern Med 2008;149:185-191
8) Qaseem A, Barry MJ, Denberg TD, et al. Screening for prostate cancer: A guidance statement from the clinical guidelines committee of the American College of Physicians. Ann Intern Med 2013;158:761-769
9) James JT. A Sea of Broken Hearts-Patient Rights in a Dangerous, Profit-driven Health Care System, 2007. Author-House, Bloomington, IN
10) Curtis CJ, Niederman SA, Kansagra SM. Availability of potassium on the nutrition facts panel of US packaged foods. JAMA Intern Med 2013;173:828-829
11) Frieden TR. Government's role in protecting public health. N Engl J Med 2013;368:1857-1859

Find past newsletters:
http://patientsafetyamerica.com/e-newsletter/

Answer to question this month: b) 736 (ref. OEI-02-09-00603, June 2013)