PSA

Patient Safety America Newsletter

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

***Question**: An American woman shows up at an ER in the U.S. overdosed on opioid pain killers about every_____ minutes:*

a) 30 b) 20 c) 10 d) 3 e) 2

Are You Nuts?

I suspect that some of those who share life with me think I am nuts, which in this context means I have a diagnosable psychiatric condition. I am given to temper tantrums, forgetfulness, distractions, and overeating. According to the latest edition of "The Diagnostic and Statistical Manual of Mental Disorders," I might have disruptive mood dysregulation disorder (tantrums), neurocognitive disorder (forgetfulness), attention-deficit disorder (distractions), and binge eating disorder (overeating). I am nuts!

An MD commenting in the *Annals of Internal Medicine* was highly critical of this latest edition of the manual because of what he called "diagnostic inflation."[1] The author notes that drug companies are happy about all this because they can sell you a pill for just about any mental imbalance you may be experiencing. There is widespread agreement from the professional community that the manual goes too far and failed to consider cost-benefit and risk-benefit outcomes. But that is understandable given the lack of scientific data available on these alleged mental illnesses. According to the author of the article, the American Psychiatric Association, which created the manual, refused to allow independent scientific review requested by more than 50 mental health associations.

Please do not misunderstand me; I know there are plenty of people with genuine mental disorders, and they need treatment. Using limited resources to misdiagnose and mistreat those without a mental illness simply wastes precious resources. It can also stigmatize one as unfit for certain privileges. Heck, in Texas we are doing all we can to make sure everyone has a gun, but if you are diagnosed with a mental illness, you might be one of those not allowed to have a legal gun. This possibility really has me worried (somatic symptom disorder); maybe I'll have to get my gun on the illegal market. Oh well, pass the box of cookies and cold milk; it's time for me to find comfort in my binge eating disorder.

First, Do No Harm - to My Wallet

Everyone is familiar with the "Hippocratic admonition" to "First, Do no Harm." Three MDs writing in the *JAMA* note that physicians have a new responsibility to "First, Do No (Financial) Harm."[2] The authors point out what many Americans know all too well: medical bills are a leading cause of financial harm, the cost of medical care keeps many from seeking medical care they need, and insurance companies do not pay for care or leave a high portion of the cost to the patient. The authors call for physicians to be more aware of the costs associated with their recommendations to patients. This is something that should be openly discussed with patients when options for treatment are being considered.

The MDs give some interesting examples of how physicians can be more cost conscious. One that struck

me personally was a recommendation on low back pain. A doctor might tell the patient that he could prescribe physical therapy for back pain but this is not covered, or only partially covered, by insurance. However, the doctor could recommend some specific exercises or note that yoga has been found effective for back pain, so the patient should consider this less-expensive option. I might note that stress is an invitation to illness and the stress of how to pay for medical care can be a health risk for many people. I know of young people who get specific physical ailments when they are stressed by life circumstances, including the concern over the cost of medical care. **An empowered patient knows when to let their doctor know that cost is a factor for them when it comes to choices in medical care.**

Dirty Secrets!

Two MDs wrote a refreshingly patient-centered article in the *Annals of Internal Medicine* which they called "The Transparency Imperative."[3] The writers forthrightly survey the two big secrets held by the medical industry: unpredictable costs and unknown quality of care. In this situation consumers are forced to take financial risks and health risks of unknown magnitude.

The writers take on many facets of the medical industry. Why are we not told the costs of tests, physicians' fees, and hospital charges beforehand? Why can't we find out how often a procedure is performed at a given hospital to assess the experience base there? Why don't we have access to all the quality data collected and why is that data so vague? Why don't health plans lead in quality transparency? One I would add is why can't we find out what we need to know about our physician's history and capability?

My fear is that we Americans have gotten so used to this parasitic way of doing business that it no longer upsets us. Outlandish costs and risky care are just part of the business model. It is time for us to wake up and hold medicine to the same standards we hold other industries where lives are at stake. There is an Occupational Safety and Health Administration to protect workers from dangerous working conditions; why isn't there a Patient Safety and Health Administration to protect patients from dangerous and overpriced medical care? The Agency for Healthcare Research and Quality and the Patient Centered Outcome Research Institute do exist as government entities, but they do not directly look after patients' safety – they sponsor research.

Physician Performance and Behavior

One of the great challenges of being a doctor is to balance the quality of care with the cost of too much care. Various standardized measures have been developed to assess the quality of care delivered to patients by specific physicians. When physicians know they are being watched, so to speak, they tend to overuse testing. An MD writing in the JAMA surveys the difficulty of balancing quality of care and overuse.[4] Investigators often use the VA Hospital system to measure performance and overuse because the data are readily available and the VA has been progressive in improving quality of care.

Recent investigations have shown a potential 8% over-treatment rate of veterans with a blood pressure below 130/65 mmHg when the action level is above 140/90 mmHg. In another study, redundant lipid profile testing was found to occur in almost 1/3rd of patients that had not had their lipid medication changed in the past year. The author points out that while lipid profiles are inexpensive, massive overuse leads to significant cost.[4] His point ultimately is that physician performance measures must be able to foster improvements in quality of care without pushing physicians into costly overuse. **I would add that patients have a role in this situation. Be informed about your illness and ask why you need to have a blood pressure lower than 130/65 mmHg or why you need yet another lipid profile when you had one just a few months ago.**

The Pain of Painkillers

The number of women dying from use of prescription pain killers skyrocketed 5-fold from 1999 to 2010 according to a government report (http://1.usa.gov/15Rj8RV). The use of such drugs has increased to the point that in 2010 enough opioid pain killers were prescribed to give the equivalent of a standard dose of hydrocodone every 4 hours to every adult in America for a month. Men are more likely to suffer from use of these drugs, but women are more likely to seek care at the ER. The number of ER visits by women in 2010 from opioid use /abuse was 130/100,000 population.

The writers of this survey make the following recommendation: "Health-care providers should follow guidelines for responsible prescribing, including screening and monitoring for substance abuse and mental health problems, when prescribing opioid pain relievers." During the survey period (1999-2010) a total of 48,000 women died from overdose of opioid pain relievers. Some very large pill mills specializing in pain killers have been eliminated from dispensing their poisons (http://www.businessweek.com/articles/2012-06-06/american-pain-the-largest-u-dot-s-dot-pill-mills-rise-and-fall), but the rate of increase of poisoning in women must be considered alarming.

Do You Really Have Cancer?

I know cancer better than I would like to. My medical research in the late 1970s involved a colon cancer model in mice. I was struck by the fact that one strain of mouse readily got colon cancer from the treatment given them and the other strain, given an identical treatment, exhibited no more than a rare microscopic spot with a small collection of cells that looked like cancer. Much more recently I have done battle with cancer – and won – thanks to some excellent surgery, but I have several friends who have lost or are losing the battle with cancer.

Cancer is an ugly disease. What most people do not understand is that it is not a single disease and there are many "cancers" that are not life threatening. Three MDs writing in the *JAMA* propose that physicians start calling indolent "cancers" something else. This would be tumors that have little chance of progressing to a life-threatening disease. They offer a compelling argument centered on the fact that major cancer screening programs that lead to removal of "precancerous" breast lesions are not reducing the incidence of invasive breast cancer. In contrast, removal of "precancerous" colon lesions does reduce the incidence of invasive cancer. Their term for non-invasive lesions would be called IDLE (indolent lesions of epithelial origin).

What I know is that the devil is in the details. For a specific patient, how does an oncologist decide whether a lesion is IDLE or cancer? The only way, and the authors propose this, is a registry with objective diagnostic criteria and continuing surveillance of the presumed IDLE lesion. In my opinion this is challenging because pathologists often do not agree on how to diagnose cancer – I saw this when I had prostate cancer. In addition, some lesions initially thought to be IDLE are ultimately going to be invasive, and this may be difficult for patients to accept. **The message for patients who have been diagnosed with "cancer" is to ask a lot of questions, do your homework, and get a second opinion if you want additional expertise before making a life-altering decision.**

Sodium, Blood Pressure, and Your Health

Most of us will have to deal with high blood pressure if we live into our 70s, yet the way we should do that is by no means clear. There are two general ways to attack the epidemic of high blood pressure in the U.S. The first is at the individual level and the second is at the environmental level. Although some physicians argue that no one has shown that treating blood pressures below 160/100 has been shown to reduce mortality, the

prevailing consensus seems to be that blood pressures above 140/90 in the general population require some intervention. Two MDs writing in the *JAMA* explore the infrastructure needed to manage blood pressures appropriately.[6]

Five aspects of the Kaiser Permanente system in California help us understand the reasons for its success. These include: 1) electronic medical records available to all care-givers, 2) tracking blood pressure control rates in the entire population, 3) having consistent guidelines that still enable physician decision-making autonomy, 4) medical assistant follow-ups, and 5) simple, generic, single-pill therapy. Although I might like to have seen lifestyle interventions as a first line of treatment, the integrated nature of this approach is noteworthy. It finds patients with high blood pressure and within reason, ensures their continuing care until their blood pressure is 000/00.

As far as our overall system of management of high blood pressure, the U.S. seems to be getting failing marks. Several European nations have successfully mounted campaigns to reduce sodium in the diets of their population, but that does not appear to be happening in the U.S. Three investigators asked whether sodium content in our manufactured foods and restaurants has been going up or down.[7] They note that 80% of the sodium we consume originates from these two sources. The study involved more than 400 processed foods and almost 80 fast-food restaurants evaluated from 2005 to 2011 and was sponsored by the Center for Science in the Public Interest.

During the study period, the average amount of sodium in processed foods declined by about 3.5%, whereas the sodium in fast foods increased by 2.6%. In recent years the American Public Health Association has called for a 75% reduction in the amount of sodium in processed and fast foods. Their goal is to achieve a consumption level of only 1500 mg/d, which would be a huge drop from the current rate of about 3500 mg/d. The Institute of Medicine has argued recently that dropping consumption to 1500 mg/d is not necessary; however, no one would look at the recent data on processed and fast foods and say that we are on track achieve a nation of people that eat wisely in order to avoid high blood pressure. The writers note 12 companies that have made commitments to reduce sodium in their foods. Many have a benchmark timeline at 2015**. In the meantime, you as a wise consumer can manage your sodium intake by eating less processed and fast food.**

References

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Answer to question this month: d) once every 3 minutes (news from the CDC)