# Patient Safety America Newsletter

July 2014 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: Of 11 developed countries studied by the Commonwealth Fund, where does the US rank regarding safety of care?*

***a) 1st b) 4th c) 7th d) 9th e) 11th***

## *Mirror, Mirror, Why Does the US Look So Bad?*

In past newsletters I have revealed the awful standing of the U.S. healthcare care system when compared to that of other developed countries. The most recent findings (June, 2014) originated from studies sponsored by the Commonwealth Fund, which is based in New York City. The authors of the study used 80 criteria to compare the essence of healthcare care in 11 developed countries.[1] The data


originated from surveys of patients and primary-care physicians in those countries. In summary, the rankings were based on quality of care (effective care, safe care, coordinated care, patient-centered care), access (cost-related problem, timeliness of care), efficiency, equity, and healthy lives.

Given this paradigm for assessing each system, the U.K. came out number 1 and the U.S. came out last. The major weaknesses of the U.S. system (11th ranking) were cost problems, efficiency, equity, and healthy lives. "Healthy lives" consists of 3 elements: 1) mortality amenable to healthcare, 2) infant mortality, and 3) healthy-life expectancy at age 60.

Despite the embarrassing showing by a country that claims that it was founded on Christian principles, one of which is to minister to and heal the sick, we have done "well" on only one measure – ours is by far the most expensive system *per capita* among the 11 nations studied. Our healthcare industry manages to extract $8,500 per person from our economy, whereas the average *per capita* cost in the other 10 countries is $4,400 per person.

In terms of our gross domestic product (GDP) a comparison over time shows that the U.S. has gone where no other country dared to go. In 1980 the percent of GDP spent on healthcare ranged from 6% to 9 %, with the U.S. and Switzerland sharing the top spot at 9%. By 2011, the last year of the study, the healthcare industry consumed 18% of the U.S. GDP, whereas the range for the other 10 countries was from 9% to 12%. All of this predated implementation of the Affordable Care Act, which may or may not make a difference.

The authors of the study note that the most notable difference between the fragmented U.S. system and that in all the other countries is that all other countries have universal health insurance coverage. They further point out that U.S. physicians are plagued by problems getting timely information on patients, by coordinating care, and by dealing with administrative hassles.

## *Think Twice about Steroid Injections*

The Food and Drug Administration (FDA) has issued a warning that corticosteroid, epidural injections for neck, back and other pain poses a small risk of very serious outcomes, including stroke, paralysis, brain swelling, and death.[2] Such injections have not been approved by the FDA as safe and effective, but are, none the less, a common treatment. Harmful events are reported to have occurred within minutes of the injection to 2 days afterward. The drug will receive a warning label. You may recall that such injections made big news after the New England Compounding Center provided many doses of their steroid formulation with fungal contamination. This killed or injured hundreds of people.

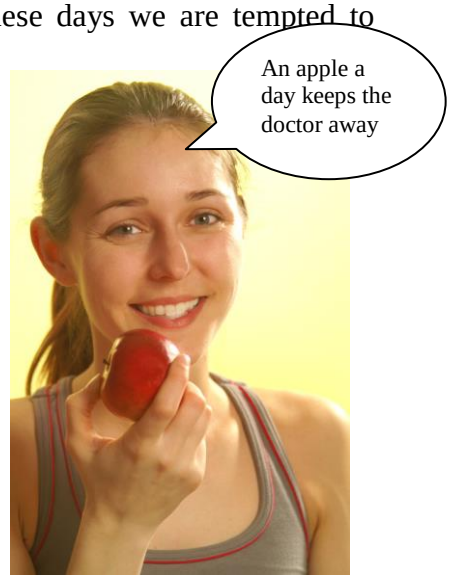
One must wonder if many of the side effects are due to poor injection technique. One might also wonder if patients are given enough information to make an informed decision about use of such drugs off label. If not, this is human experimentation without oversight – a criminal act.

## *Heart Attack Risk from Elective, Non-Heart Surgery*

A study was just reported at a session of the American College of Cardiology conference in which strategies to reduce the risk of heart attack and death from elective surgery were discussed in disappointing terms.[3] Non-cardiac surgery causes activation of platelets and increases the risk of blood clots. It was thought that blocking this would improve outcomes, but it did not. Aspirin and clonidine were studied and the outcomes were 7% heart attack or death (aspirin) and 3-4% heart attack or death (clonidine). Patients were followed for 30 days after surgery. There were unpleasant side effects: major bleeding with aspirin and low blood pressure with clonidine. The authors of the study are going back to the drawing board to try another drug. If I were a patient contemplating elective surgery, I would think twice about how badly I needed that surgery. I would certainly ask about the alternatives.

## *Diet and Health*

An article in the *JAMA Internal Medicine* calls for improving physician knowledge of nutrition as it bears on prevention of disease.[4] Two writers that pioneered an emphasis on nutrition in medical education in the 1970s were happy to see that attention has returned to this important issue after decades of neglect. These days we are tempted to consume high-calorie, nutrient-deficient, convenience foods almost any time of day; this has hit home for me since my retirement. Primary-care physicians need to be prepared to council their patients on ways to improve nutrition, or at least direct their patients to a clinical nutritionist. There are government surveys prepared for patients that will identify nutritional deficiencies.[5] It may be time for you to think how poor nutrition could be affecting, or will be affecting your health.[6]




## *Clinical Practice Guidelines for Cardiologists*

Physicians, especially cardiologists, are notorious for not following guidelines when it comes to the care of their patients. But guidelines are fluid over time. A team of researchers asked how many of the "index recommendations" in major cardiology guidelines were altered or deleted in the subsequent guideline versions from 2006 to 2013.[7] Of the 619 index guidelines, 495 were retained and 124 were downgraded or omitted. As one would expect, the guidelines most likely to be downgraded or omitted were those based on "expert" opinion rather than on multiple randomized studies. The informed patient knows there are guidelines for care of their heart and will insist that guidelines be followed unless there is a compelling reason to deviate from guidelines.

An editorial related to the above study asked what triggers an update, how quickly can the guidelines be updated, and how are the changes communicated to front-line cardiologists.[8] Triggers

for change come 2-5 years after publication of a critical study and modification of the guideline by experts can take several years if appropriate reviews are undertaken. The author finds this delay unacceptable, and I would agree. As far as communication is concerned, simply publishing the new guideline is insufficient. The changes and the rationale for the changes must be systematically given to clinical cardiologists. In my opinion, the greatest problem is getting front-line cardiologists to read and heed the guidelines. No one holds them accountable for doing that.

## *Stories that Matter*

One of my favorite pastimes has been to tell stories to my children and more recently to my grandchildren. Sometimes I rivet their attention with scary tales and at other times I get them to laugh at the antics of my make-believe witches, ghosts, or super-heroes. At times I also try to convey a moral message so that they will learn how to become ethical human beings. I could not help but notice this month as I read journals that there were several stories published that were meant to foster better medical care. Herein I'll summarize some of those stories.

An MD and long-time diabetic tells how, despite his clear warnings to those who would be caring for him during a surgical procedure, his caregivers were determined to give him an IV dose of glucose that would have raised his blood levels to 700 mg/dl – clearly dangerous and a high risk for death in a 78-year old man.[9] This was necessary because the rules of the hospital required it. The doctor clamped the tubing that was delivering the glucose and found an informed nurse who promised to check his glucose every half hour during surgery. The doctor points out in his perspective article that giving a patient medication (glucose in his case) against his will is a felony. One can only wonder what might have happened if the patient had not been a physician.

Two MDs tell the story of a man in his 80s admitted to the hospital for bowel surgery.[10] He had several chronic illnesses, but no evidence of heart problems; however, the hospital, following its common practice before surgery, subjected the man to an echocardiogram. This was interpreted to indicate severe left ventricular dysfunction and possible clot, so he was subjected to an echocardiogram *with contrast media*, and this test showed an even worse ventricular dysfunction, so surgery was postponed because, as the patient was told, it would be a death sentence. None-the-less, several days later his bowel obstruction was removed and after he recovered some, he was subjected to a cardiac catheterization, which showed normal ventricular function and no evidence of clots. In the opinion of the writers, a more complete physical would have shown that the initial echocardiogram was unnecessary; indeed, there is lack of evidence that a pre-operation echocardiogram benefits patients at all. All this man's echocardiogram did was prolong his hospital stay, subject him to a risky and expensive cardiac catheterization, and cause him and his family unwarranted stress and worry.

In an article entitled "The $50,000 physical," an MD writes about his father's experience.[11] As part of a routine physical of this 85-year old man, the primary care doctor thought he felt a too-prominent aorta, so he ordered an abdominal ultrasound. The imaging showed a normal aorta, but there appeared to be something on the pancreas, so a CT scan was ordered. The pancreas was normal in the scan, but there appeared to be a single lesion on the man's liver, so a biopsy was performed. The lesion turned out to be a non-cancerous hemangioma, which is a nest of blood vessels. The biopsy disturbed the nest and the man nearly bled to death, requiring 10 units of blood. His total hospital bill was $50,000. The MD writer declared that unless there are clear indications of something wrong in the patient's abdomen, and there are

patient complaints, the doctor should just stay away from the abdomen.

The writer noted that there is substantial downstream revenue generated for the health system if a "wild goose chase" [my words] is initiated. The author questions the value of a routine physical when the patient has no new health complaints. Unfortunately, Medicare pays for these things regardless of need. The writer concluded that "we [physicians] have a long way to go in educating the next generation of physicians to 'do no harm.'" In my opinion, we must get the fee-for-service model behind us and pay only for what benefits the patient.

A retired attorney writes of her experience with cataract surgery.[12] She was given an electrocardiogram before the surgery and it allegedly showed evidence of a past heart attack, so she underwent an exercise stress test. The stress test showed some abnormalities, so a cardiologist recommended a myocardial perfusion test, which involves considerable radiation exposure. The cardiologist failed to disclose this to the patient. She consulted another cardiologist whom she characterized as "superbly well-qualified." That cardiologist, after reviewing all her data, declared that her heart was normal, and there was no need for further testing. The writer makes it clear that this sort of thing has got to stop. Extensive and expensive tests without discussing the risks and benefits with the patient must cease. I would add that such practice constitutes failure to perform informed consent, which leads to battery by invasive testing, which is a felony.

## *Swiss Medical Board on Mammography*

The controversy regarding screening for breast cancer continues unabated. The latest salvo involves the decision by the Swiss Medical Board that the preponderance of evidence shows no life-saving value of such screening. Two experts involved in the Board's decision wrote a defense of that decision in the *New England Journal of Medicine*.[13] The medical board itself is not a governmental agency, so its decisions are not binding; however, this expert group came down convincingly on the side of no screening, and they feel that women need to be told this, and women are not being told this. Furthermore, it is unethical, in their opinion (and mine) to promote a procedure that has not clearly demonstrated more benefits than risks. One thing that seems not to be emphasized in the dialogue – and I will emphasize it here – women with risk factors for breast cancer are much more likely to benefit from screening than women with no risk factors.

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Answer to question this month: c) 7th in reference #1