Patient Safety America Newsletter

February 2015 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: The per capita cost of medical care in the U.S is $8,900 per year (http://data.worldbank.org/indicator/SH.XPD.PCAP). Infant mortality, life expectancy, and maternal mortality are much better in Sweden than the U.S. What is the annual per capita cost of healthcare in Sweden?

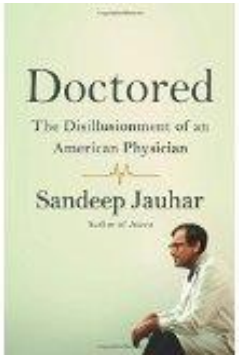
a) $4000 b) $5000 c) $6000 d) $7000 e) $8000

Book Review:

Doctored – ***The Disillusionment of an American Physician***

By Sandeep Jauhar, MD

Dr. Jauhar's writes a deeply personal account of his manifold struggles to practice medicine as a heart-failure cardiologist in a New York hospital. He is trapped within walls built by his need to spend time with his growing family, insufficient income working only as a hospital doctor, social pressures from his well-healed, charming brother who is an interventional cardiologist, and finally the poisonous lures borne of schemes to make more money as a part-time, private-practice cardiologist.



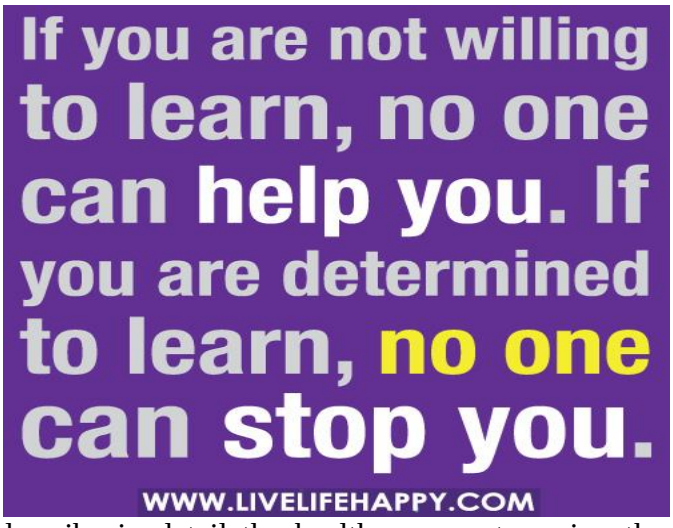
Laced within his personal struggles at mid-career the reader discovers disturbing vignettes describing the woeful history and current state of medicine in general in the U.S. These tell of thousands of unnecessary surgeries, futile treatments at the time of death, missed diagnoses, government ineptness, and widespread deceptions. As Dr. Jauhar's walls close in on him, he is impelled to partner part-time with colleagues in private practice. There he finds brutally aggressive tactics that make patients pawns in the game of referral acquisitions and the money that flows from referrals.

Ultimately he manages to recover his core values that center on patient wellness and finds a way to push aside the walls that have trapped him in his professional prison. He renews his family ties and discovers the wisdom of time with his "little one."

For most readers I do not think this book will reveal anything new about our broken medical care system. The value in reading this book is to learn how difficult it can be to practice medicine in the U.S, a country poisoned by dysfunctional sub-systems that are broken for almost everyone – except high-earning specialists. They are willing to view it as a steamy enterprise in which patients and many physicians can be exploited for profit. It is doctors like Sandeep Jauhar with which patient-safety advocates can partner to improve medical care in our country. He tells ugly inside truths, and does it with honesty and compassion. I hope there are many more like him out there. Five stars.

When Will We Ever Learn?

The *New England Journal of Medicine* started a series of perspective articles in January that



describe in detail the health care systems in other countries. An editorial pointed out that all systems all have their shortcomings, but there may be some

"hidden gems" even in the lessons available from less-wealthy countries.[1] As a practical matter, the treatment for two hypothetical patients – a young pregnant woman and a middle aged man with a heart attack – will be described in the system from each country. As I pointed out last month, a respected economist has estimated that if we spent as much of our GDP on healthcare as the country just below us in GDP expenditures, we would save a trillion dollars per year.[2] Our failure to learn from other countries is absurd.

The first country's healthcare system to be described is Sweden.[3] Sweden (officially the Kingdom of Sweden) is a Scandinavian country of about 10 million people with a king, prime minister and a unicameral, 349-member parliament (Ritsdag) that appoints the prime minister. All political parties receiving more than 4% of the vote have population-proportional seats in the Ritsdag. Historically, the Social Democrats have dominated politics.

All citizens of Sweden have access to high-quality medical care at a fair cost. Physicians are salaried, with the average base salary for a senior physician being $92,500.[3] The per capita expenditures are about 60% of the U.S. and this comes primarily from taxes. Life expectancy is 82 years, the infant mortality is 0.2 %, and maternal mortality associated with live births is 0.004 %. These numbers are far better than anything the U.S. non-system can hope to offer its citizens. In principle, citizens can chose their doctors, but there can be long wait times for elective treatment. It seems that the Swedish people have a much stronger desire for equity in healthcare than Americans.

How did the hypothetical pregnant woman and man with the heart attack fare in Sweden? The newly-pregnant woman received frequent visits and counseling on ideal maternal behavior and birthing. These visits become more frequent at about 24 weeks of pregnancy. She is much more likely to deliver her baby vaginally (80%) than an American mom (68%). She has no copay associated with the entire process. The fellow with the heart attack was taken immediately to a hospital by ambulance where he was evaluated and received immediate treatment as necessary. He is held in the hospital about 4 days, and then sent to rehabilitation as appropriate. Procedures including coronary artery bypass surgery may be provided if necessary. All of this medical care is publically funded; however, he may incur copayments of up to $150 per year for office visits and $300 per year for drugs.[3]

Recently there has been movement toward privatization of healthcare in Sweden, but with the government swinging back toward the left, this may be halted or reversed.

In my opinion, there are obvious lessons in this perspective. A unicameral parliament from which the prime minister is chosen seems to head off the mindless polarization we have witnessed in Washington over the past few years. The salary of physicians is far less than those earned in the US, but the national outcomes and per-capita costs are far better. Sweden's attitude of equity in access to healthcare does not seem to be present in much of the US.

Forgotten Equity

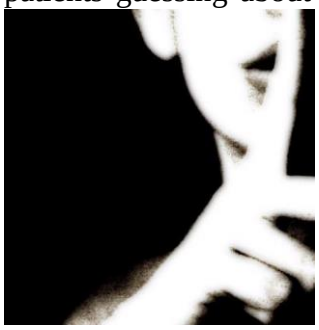
Many doctors in the US are rightly concerned about low fees paid to them by Medicare and Medicaid. In fact, many are opting out of these government programs because of low fees. A perspective article written for the *New England Journal of Medicine* by a lawyer asks what the effect of low physician fees has been on access to care by Medicaid beneficiaries.[4] It seems that most Medicaid beneficiaries (there are 66 million of these) live in areas that already struggle to meet the health needs of the community. Medicaid payments for physician services are on average much lower than for Medicare patients. Community health centers seem to help this access problem for primary care, but access to specialists is much more limited.

Interestingly, the federal government has a law declaring that states must give Medicaid beneficiaries access to services equivalent to the

prevailing access level for the general population of their state. The author of the perspective suggests that the federal government needs to do what it is supposed to do, which is to implement the long-delayed equal-access regulation. In my opinion, given the tension between state and federal governments involving Medicaid access and payments, this will be like pouring gasoline on the flames of discord. Of course, this will result in copious litigation, delays will go on for years, and more Americans will be harmed by our chronically debilitated healthcare non-system.

Transparency – Really?

The medical industry maintains a plethora of secrets, many of them surprisingly dark, that keep patients guessing about how to find safe, equitable and affordable medical care. Furthermore, when something goes wrong, obtaining accountability for any errors that caused harm is often elusive. Three articles on transparency caught my eye this month.



The first extolled the transparency breakthrough of Medicare reporting its payments to physicians in a database accessible to the public.[5] Release of these data had been blocked by the Florida Medical Association on grounds of physician privacy. Ultimately, the data were only marginally useful, but the database is a small step in the right direction. For example, patients can now see the volume of an individual physician's performance of a given procedure, but data on non-Medicare patients is not included. The MD author notes his belief that high-procedure-volume is at least somewhat predictive of a better outcome for individual patients. In my opinion, it is transparency through smoky glass.

In a second article on transparency, three MDs from Europe wrote about the value of drug companies being forced to share their clinical trial data.[6] The European Medicines Agency, located in Naples, Italy has taken steps to require access to documents related to human-use medicines (2010), and later to disclosure of clinical data used in publications on human-use medicines (2014). The agency feels that open disclosure of new data promotes innovation among drug developers and protects against drug company complaints of disclosure of confidential information.

A third publication called "SHINING A LIGHT - Safer Health Care through Transparency" came from the National Patient Safety Foundation in January. This 43-page "booklet" provides a thorough discussion of where improvements in transparency are needed.[7] One thing I noted right away was that several patient safety leaders from the non-medical community were involved in the formation of the document. The document notes that there are four fundamental reasons for increased transparency: (1) to promote accountability, (2) to catalyze improvements in quality and safety, (3) to promote trust and ethical behavior, and (4) to facilitate patient choice.

These are ideals, but the reality is that endemic barriers to transparency exist. These are as follows: (1) fears of conflict and negative effects on reputation and finances, (2) lack of will of leaders to create a culture of safety, (3) stakeholders that desire to keep the status quo, and (4) lack of reliable definitions, data, and standards for reporting.

The document creators, seeming to divide everything into fours, also listed four domains for improved transparency. These were as follows: (1) between clinician and patient (e g. after a medical error), (2) between clinicians (e g. during the peer review process in hospitals after an adverse event), (3) between health care organizations (e g. by collaborative formation for data exchange), and (4) between clinicians and organizations with the public (e g. public reporting of quality and safety data).

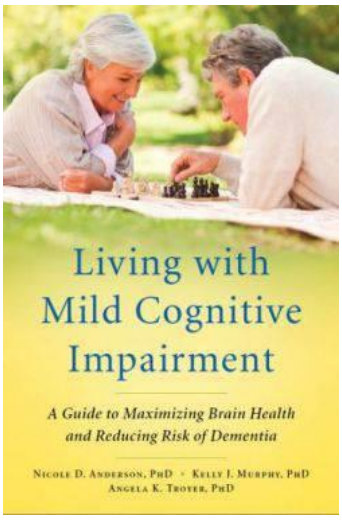
The document concluded with a "Call to Action." This was addressed to each of the stakeholders in the patient-care process, either collectively or individually. There were 39 of these; some of the highlights I liked were as follows: disclose all potential conflicts

of interest, ensure patients have complete and unbiased information, full transparency of board membership, robust medical device registries, use of federal agency power (CMS) to require full data disclosure as a "Condition of Participation (COP)" in Medicare and Medicaid payments, provide each patient with a full description of procedures and alternatives, reward transparency and create consequences for not speaking up, and develop processes to address disruptive behavior and substandard individual performance (e g. 360 degree reviews).

To put it mildly, I embrace this list! I like the idea of using COP leverage to force better transparency, although my limited experience with COP has not been encouraging. I like the idea of consequences for those who do not speak up about potential harm. There is plenty of precedent for this. Teachers who fail to report signs of child abuse can lose their jobs. Finally, the use of 360 reviews to improve professional behavior and substandard performance is something I have been promoting for several years.

Ultimately, the document is no more than words until the medical industry, government officials, legislators, hospitals, medical societies, and clinicians decide to give up the old ways of secrecy for the modern concept of full transparency. As a patient, you should demand transparency in all situations.

Mild Cognitive Impairment



Those of us who are Medicare age and beyond know first-hand that mild cognitive impairment is a natural consequence of normal aging. An article in the *JAMA* addressed potential non-natural causes of mild cognitive impairment and ways that it might be held at bay or reversed.[8] Clinicians were told to consider depression, polypharmacy (too many interacting prescription drugs), and uncontrolled cardiovascular risk factors (e g. high blood pressure) as causes of impairment. Since there is no effective drug treatment for mild cognitive impairment, patients should be encouraged by their doctor to engage in moderate exercise that elevates their heart rate, engage in mentally-demanding activities, and foster social connections. I like these non-medical solutions to avoid or reverse mild cognitive impairment.

References

1) Morrissey S, Blumenthal D, Osborn R, et al. International health care systems. *N Engl J Med* 2015; 372:75-76. http://www.nejm.org/doi/full/10.1056/NEJMe1415036
2) Fuchs VR. Critiquing US health care. *JAMA* 2014; 312: 2095-2096. http://jama.jamanetwork.com/article.aspx?articleid=1918556
3) Anell A. The public-private pendulum – patient choice and equity in Sweden. *N Engl J Med* 2015; 372:1-4. http://www.nejm.org/doi/full/10.1056/NEJMp1411430
4) Rosenbaum S. Medicaid payments and access to care. *N Engl J Med* 2014; 371:2345-2347. http://www.nejm.org/doi/full/10.1056/NEJMp1412488
5) Adashi EY. Transparency in action: "The imperfect is our paradise." *JAMA* 2014; 312:2607. http://jama.jamanetwork.com/article.aspx?articleid=2084877
6) Bonini S, Eichler H-G, Wathion N, Rasi G. Transparency and the European Medicines Agency – sharing of clinical data. *N Engl J Med* 2014; 371:2452-2455. http://www.nejm.org/doi/full/10.1056/NEJMp1409464
7) The National Patient Safety Foundation. SHINING A LIGHT – Safer Health Care through Transparency. Boston, MA, 2015. http://www.npsf.org/general/custom.asp?page=shiningalight
8) Langa KM, Levine DA. The diagnosis and management of mild cognitive impairment – a clinical review. *JAMA* 2014; 312:2551-2461. http://jama.jamanetwork.com/article.aspx?articleid=2040164

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

Answer to question this month: b) $5300 is the best answer, reference #3.