



# Patient Safety America Newsletter

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**Question:** If the infant mortality in the U.S. were as low as that in the United Kingdom, how many more babies would live through the first year of life in the U.S.? a) 700 b) 7,000 c) 70,000 d) 700,000

## An Ugly Superbug

*Clostridium difficile* (C diff) infections are growing at an alarming rate in the U.S. A study published this past month in the *New England Journal of Medicine* described the burden of C diff in terms of human suffering, noting as an aside that the excess healthcare cost of such infections approaches \$5 billion per year.<sup>1</sup> The authors performed a C diff surveillance across ten regions of our country, classifying the disease as community-associated or healthcare-associated. More than 15,000 cases were identified in these regions, and from this they estimated that about 450,000 C diff infections occur each year in the entire U.S. The investigators' estimated number of deaths was just under 30,000 per year, which is about the number of people that die in vehicle accidents each year.

What troubled me was that about two thirds of the infections were healthcare-associated and only one fourth of those became evident during hospitalization. An empowered patient will be vigilant for the development of such infections after hospitalization. The Mayo Clinic has provided a guide on the symptoms of C diff infection and how to manage it ([C diff symptoms](#)). Antibiotic stewardship (prescribing antibiotics only with clear need) in the United Kingdom has proven to reduce the incidence of C diff, and belatedly in the U.S. we are focusing more attention on this problem.

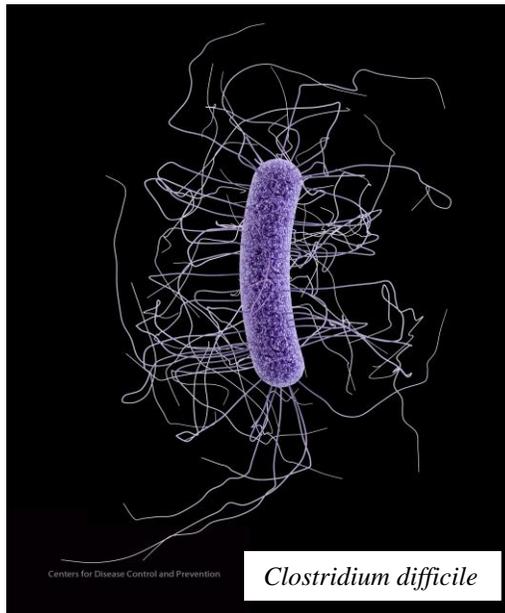
## Opioid Worries

A team of specialists described the conclusions of a workshop entitled "Health Pathways to Prevention," which was conducted by the National Institutes of Health and focused on the role opioids should have in treating chronic pain.<sup>2</sup> This is not a small issue. By the authors' description, many millions of Americans use opioids to manage their pain, yet many are left to deal with poorly controlled pain. The number of opioid prescriptions has increased almost 3-fold in the years from 1991 to 2011. In the wake of this increase, addiction and accidental overdose deaths have risen. The authors point out that healthcare providers are often not properly trained to manage chronic pain.

The authors point out that pain management should first include physical therapy, behavioral therapy and possibly alternative non-pharmacological

treatment (e.g. acupuncture) if it has been shown to be effective. Management of serious, ongoing pain will require frequent visits to the doctor.

In my opinion, the message to patients is to make sure all non-opioid options are exhausted before you use opioids to manage your pain. You should also consult a genuine expert in pain management, but do not be victimized by a "pill mill." Here is a website that seems to offer a balanced discussion of various pain-management options ([chronic pain options](#)). Shared decision making with your doctor about your pain means that *you* must do *your* homework.



## Medicare Advantage Plans and Quality

Once an American approaches Medicare age he will begin to receive a plethora of mail offering many different Medicare Advantage plans. Sorting out the options is not simple, but an important question is, “What quality of care will I receive while enrolled in a specific plan?” One discriminator could be whether the plan is a “for profit” plan or a “non-profit” plan. A team of investigators asked if there was on average a difference in quality ratings between profit and non-profit plans.<sup>3</sup> Quality was based on star ratings provided by Medicare in 2010.



These ratings are presented to the public as “stars” in number from one to five, with five being the best. The average “adjusted” score was 0.55 stars higher for the non-profit advantage plans than for the for-profit plans. The adjustments were made for the size, age, and operating area of the plans that were compared. These adjustments did not make much difference in the rating gap. Without the adjustments, the gap was 0.64 stars. Here is the government site for comparing plan ratings: [star ratings](#). The authors of the study opined that the low-scoring, for-profit plans need some guidance in how to improve the quality of their plans.

## Across the “Pond”

Many of you may remember the Olympics Ceremony a few years ago in which the Brits paraded out a bunch of hospital beds with “patients” in them and celebrated their healthcare system before the world. They have good reason to celebrate as a “Perspective” article in the *New England Journal of Medicine* described.<sup>4</sup> Their system is committed to whole-person care for each person with focus on primary care and wellness within defined care communities. The general practitioner manages the balance between over-

medicalization and access to specialists, advocating for the patient when necessary. The article went on to criticize the way the U.K. government has engaged with general practitioners, which obviously matters a lot since they are a sort of gate-keeper between the people and the specialists.

Before I deal with that issue, let’s look at some statistics on the system in the U.K. in terms of success or failure. The per capita cost is about \$3,600 per year, which is about 40% of the per capita cost in the U.S. The fraction of gross domestic product spent on healthcare is just over 9%, which is about half that in the US. The life expectancy at birth is 82 years – again much better than in the US. Furthermore, the first-year infant mortality is only 0.4%, again better than in the US. Salaried general practitioners make only \$91,000 per year and those who are self-employed make about \$165,000 per year.

You may recall in the comparisons of medical care systems we will look at the care of a pregnant young woman and a middle aged man with a possible heart attack. If he were in the U.K., the man with the heart attack would be given an electrocardiogram by paramedics who see that a heart attack is likely when they encounter the man. He is taken to an interventional cardiology unit where he gets coronary-artery stents if needed within 90 minutes. He is discharged in 3-4 days if he is recovering as expected. Rehabilitation, if needed, will start in 10 days. Once discharged, he is looked after for a few weeks by a specialist, and then turned over to his general practitioner for holistic care.

Our putative pregnant woman is evaluated by her general practitioner, and then sent on to care by a midwife and possibly an obstetrician, depending on how risky her pregnancy happens to be. She enjoys about ten visits under midwife care as long as there are no complications. A first delivery may more likely occur in a hospital, but that has been changing since it has been shown that at-home births presumably under mid-wife care are no more risky than in-hospital deliveries for low-risk patients.

Going back now to the issue of primary care in the U.K., a letter in *JAMA Internal Medicine* pointed out that access to primary care has been recently expanded in the U.K. so that appointments are available 8 am to 8 pm seven days of the week.<sup>5</sup> The writers note that wait times in the U.K. are shorter than for privately-insured or Medicaid

patients in the US. Furthermore, there are no fees charged for primary care in the U.K.'s National Health System.

My point in going through all this is that we Americans can do much better, but the money-driven U.S. system is not going to be easily changed to one centered on individual health rather than on the repairing of broken bodies for a large fee.

For women with risk factors, such as diabetes, high blood pressure, or likely need for caesarian section, current U.S. guidelines specify a hospital's obstetrics service as the safest place.<sup>6</sup> The key is to know beforehand what the risks are for a specific, expectant mom and have a credentialed midwife present if home birth is chosen for a mom not at risk. Home births offer substantial cost reductions. In 2010, private insurers and their enrollees paid hospitals on average more than \$20,000 for each a vaginal birth, whereas a home-birth under midwife control may cost only \$1000. Aside from the huge cost differential, the tradeoffs are the risk of infection and risk from regional anesthesia in a hospital versus the inability of the midwife to deal with an unanticipated complication during an at-home birth. Stories I know suggest that lack of pain management (regional anesthesia) during a midwife delivery is not pleasant, to say the least.

### *Uninformed Consent*

In my opinion, one of the great evils of the U.S. medical industry is failure to give patients enough information to make informed decisions about their care and genuinely engage them in shared decision making. A recent review article in the *New England Journal of Medicine* dealt with this issue.<sup>7</sup> Herein I would like to use some ideas presented there to build a discussion platform for this important topic.

The writer notes that bodily invasion, even for a blood draw, without a person's permission is battery.<sup>7</sup> The writer further notes that the reality of informed consent often falls short of the theoretical ideal. Let me give you a personal example. I have a poor blood type for donation, so the last time I did this the attendant asked me if I would like to donate plasma, which meant returning my red cells to my body. I was told that this might take a little longer than a normal donation. What I was *not told* was that the pain of returning the cells into my arm could

be excruciating. I had given my consent for a procedure based on trust, but that trust was violated by lack of information. I won't give plasma again. Maybe I'm just a wuss.

The medical writer goes on to note the "centrality" of informed consent – observing that the World Medical Association Declaration of Lisbon (2005) explicitly stated that "patients everywhere have a right to information and self-determination." The common practice of getting the signature on the consent form in the U.S. is not by any means sufficient. There is a "considerable gap" between the true intent of informed consent and the way it is obtained in practice. The writer notes that information about the value of procedures is often uncertain and this can be confounded by the patient's ability to understand her options.

In my opinion, the review fell short on two accounts. The first is that doctors often do not know the available information necessary to give the patient what she needs to know to make an informed decision. Furthermore, what they do know may be biased. This means that patients must do their homework to improve their knowledge and participate in shared decision making. For example, doctors may not even be aware that radiation associated with a procedure increases cancer risk. Furthermore, they may not be aware of evidence



based guidelines for patients with specific conditions, so they are unlikely to tell you that what they recommended to you deviates from guidelines – they may not even know it does.

The second way the review fell short was in not surveying some of the legal definitions of informed consent for clinical practice and the fact that laws designed to protect patients from lack of informed consent are seldom, if ever, enforced. **As an empowered patient you must know these laws for your state and make sure your doctor knows you know. Keep your own record of informed consent.**

In the "Less is More" section of *JAMA Internal Medicine* a doctor wrote about her experiences of having an X-ray ordered even before

any doctor had seen her.<sup>8</sup> She had had a persistent sore shoulder and had been given medications that gave her “excruciating stomach pains.” So she went to an orthopedic clinic where she was ushered to the X-ray department before seeing any doctor. She refused to have an X-ray until the orthopedic doctor explained the need. He could not. She asked what her differential diagnosis was. He gave her a scare response, “bone cancer.” He went on to chastise her for disrupting the clinic’s workflow, but the doctor-patient refused to be intimidated into compliance with her orthopedic doctor’s assertion that “This is how we practice medicine here.”

The writer went on to note that too many patients simply follow medical orders in most cases no matter how wrong the orders may seem. I thought her opinion of the causes of such practices was interesting – “defensive medicine, profitable medicine, lack of knowledge or confidence.” She notes the difficulty of balancing patient needs with for-profit medicine. She suggests that paying physicians for their time instead of all the procedures they can order would make sense. Common sense and common good, in my opinion, often fail to drive healthcare in the U.S.

### *End-of-Life Care*

This past month I was fortunate enough to attend a Lown Institute Conference in San Diego. Among the many informative sessions I attended was one on end-of-life care led by two female MDs. One of the questions posed to the participants was, “How do you want to die?” I think that is a question we each should discuss with our families and primary care physicians at least if there is reason to believe that death may be around the corner.

A “Perspective” article written by two MDs dealt with this same, difficult topic.<sup>9</sup> The authors noted the disconnect between the way doctors want to die and the way their patients die. A recent study they cite found that nearly 90% of young academic physicians would not want high-intensity care at the end of their life. They suggest that the U.S. healthcare system is not well designed to help families and patients at the end of life. They summarize recent recommendations from the Institute of Medicine as follows:

- Insurers must pay for palliative and comprehensive care near the end of life.
- There needs to be measurable standards for how physicians and patients communicate on this issue.
- Medical and social services must be integrated and supported by insurers.
- Training and certification is needed to strengthen clinician knowledge.
- Public education on this topic needs development and dissemination.

So, the action for the empowered patient is to make known how you wish to die and ask your family to make your wishes stick when the time comes. In the meantime *live well*.

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Answer to question this month: b) 6,900 based on reference 10 and 4 million births in the U.S. each year