



Patient Safety America Newsletter

February 2018

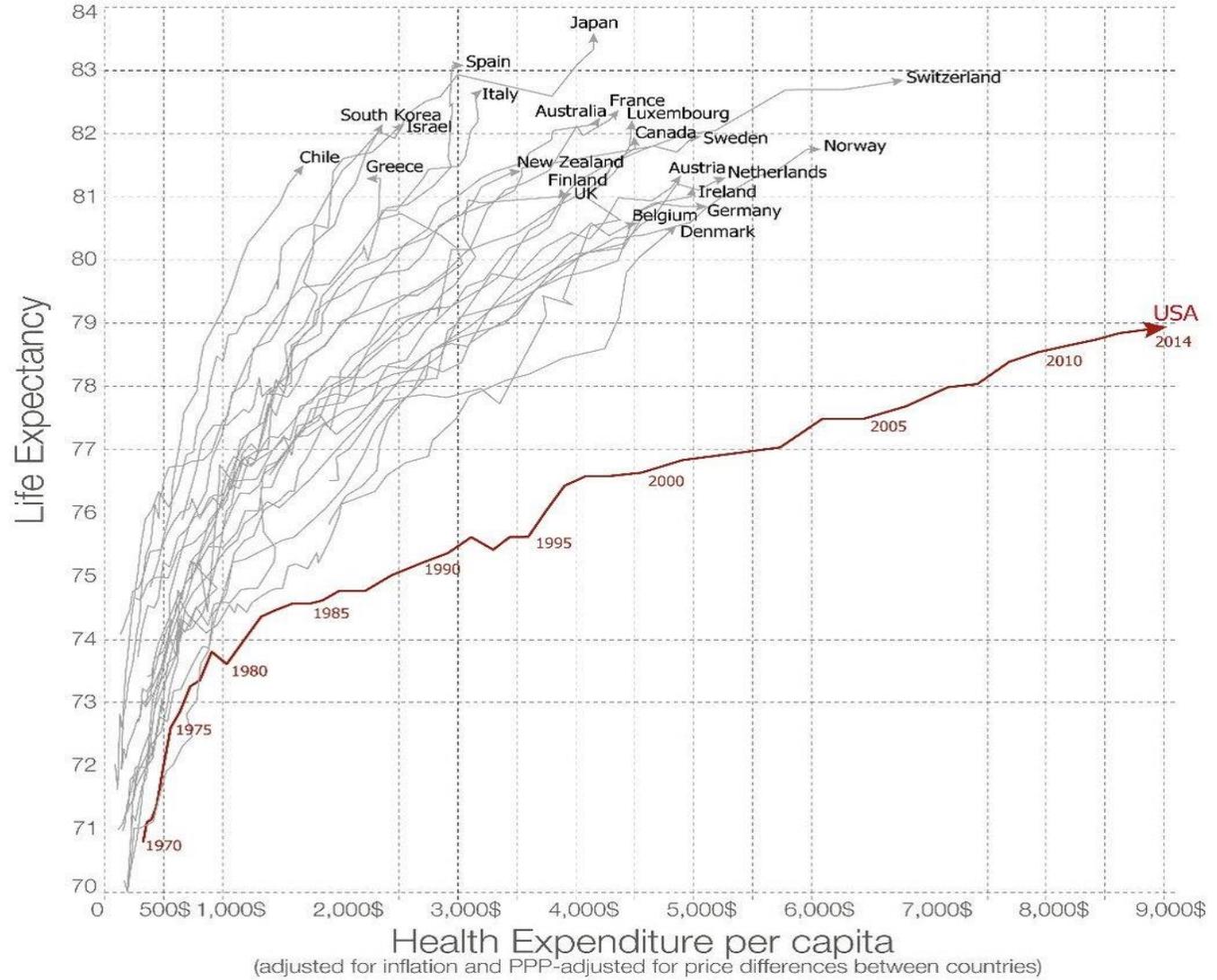
<http://PatientSafetyAmerica.com>

John T. James, Ph.D.

Question: Referring to the diagram below, estimate the U.S.A. life expectancy at birth in 2016.
 a) 78.9 b) 79.2 c) 79.4 d) 78.7 e) 78.5

Life expectancy vs. health expenditure over time (1970-2014) Our World in Data

Health spending measures the consumption of health care goods and services, including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments. Shown is total health expenditure (financed by public and private sources).



Data source: Health expenditure from the OECD; Life expectancy from the World Bank. Licensed under CC-BY-SA by the author Max Ros. The data visualization is available at OurWorldinData.org and there you find more research and visualizations on this topic.

Wrong Health Care

Two weeks ago I attended a Right Care Alliance training session in Cambridge, Mass. One of the slides shown was the one above, illustrating

very clearly why American health care is an "Alliance of Wrong Care." Inspection of the graph shows the divergence of the American line from all others starting about 1980 when deregulation was

the impulse of U.S. political leadership. This has led us to a capitalist health care system that is much less efficient than all other systems in developed countries. Part of the reason for this is our emphasis on sick care, where the big money is, rather than on keeping people healthy where big money is not the driver of care. Another factor is the lack of control of drug prices, which are much lower in other developed countries. This coupled with over medication of many Americans, has resulted in another layer of wrong care. The target of the Right Care Alliance for 2018 is the high cost of drugs, especially medications for diabetes.



Can You Hear Me?

There are two stages to hearing loss. The first is denial of the loss, and the second is awakening to the benefits of hearing aids. The second phase is often instigated by family members who are weary of shouting at the one with hearing loss. My mother experienced this in the last years of her life when everyone left the family room because she turned the TV volume so high no one else could tolerate the decibels. With her dry humor, she declared, “The problem is not my poor hearing, it is that you people hear too well.” She had hearing aids, but seldom used them. I now use them with noticeable benefit.

Two experts wrote an article in the *New England Journal of Medicine* describing the impact of [hearing loss](#), mostly in older adults. Once one gets past the technical minutiae on mechanisms of hearing loss, the article is easily readable. About half of the folks in their 60s have some hearing loss, and the vast majority have serious loss by the age of 85. Folks with hearing loss tend to fall more often,

be more frequently hospitalized, and experience depression.

Among the causes of hearing loss are the following: ageing, noise exposure, and medications. I might observe that these may go hand-in-hand. Noise exposure and certain drug exposures lead to “presbycusis.” This type of loss leads to be bilateral. The person may hear sounds, especially speech, sufficiently loud but cannot understand it.

Treatments that restore the common forms of hearing loss are not available. Many companies sell hearing aids. The authors caution that costly hearing aids are not necessarily correlated with quality. Only 1/7th of those with hearing loss wear hearing aids. The United States is one of the few developed countries that refuses to offer government assistance for their purchase. I guess the hearing aid lobby has not bought enough Congress persons. The VA managed a mass purchase of hearing aids for an average of \$370 apiece, whereas these sold for \$1400 to \$2200 on the open market. My advice to adults as they age is to get past the denial stage quickly. **Once you have done that, get tested for hearing loss, and then purchase quality hearing aids.** [Consumer Reports](#) has rated these, but you must be a subscriber. Independent advice is available on selection by type from the [Mavo Clinic](#).

Belly Aching

Two MDs writing in the “Less is More” section of *JAMA Internal Medicine* describe how a physician ought to deal with [abdominal pain in a patient](#) without necessarily relying on expensive imaging such as CT scans. It seems that 1/10th of visits to the emergency department are for abdominal pain. In general, the patient’s history and clinical evaluation lead to accurate diagnosis only half the time. In cases of acute abdominal pain (as opposed to ongoing moderate pain), the patient’s history and clinical examination identify those cases where “urgent” surgery is needed as well as CT scans. In cases deemed non-urgent, the clinician should ask the patient to return the next day for reevaluation. This requires an assessment of whether the patient is likely to return. This approach of watchful waiting is preferable to an expensive CT scan. I would add, “unless the CT scanner needs to be used to make money.” A guideline for evaluation

of abdominal pain has been developed by a [group of experts](#).

Blood Pressure (BP) Guideline

You may have heard [news](#) that a new guideline for BP management has caused millions of Americans to suddenly have high BP, and they may need treatment. Before you jump at the [guideline change](#), you should determine your [ASCVD Risk](#) score. You will need your lipid profile numbers (cholesterol, HDL, LDL) to do this. I played with this a little bit. If you want a risk of cardiovascular disease of less than 10 % in the next 10 years (the usual benchmark) and have normal lipid numbers, are taking no medications, and have a systolic BP of 140 mmHg, then your age if you are “white” is going to have to be 63 or less for men and 69 or less for women. This matters because your BP is deemed OK if you have a ASCVD risk score of less than 10%, you have no risk factors for cardiovascular disease, and your systolic BP is less than 140 mmHg. By “OK” the guideline suggests that no treatment is necessary. Normal BP is now less than 120/80, elevated at 120-129/80, and stage 1 hypertension 130-139/80-89.

One precaution I must mention here. I have two Medicare-age friends that have fallen recently while on BP lowering medications. Their injuries were not serious – this time – but their physicians reduced their dose of BP medication with the intention of reducing the risk of a fall. The guidelines specify that at-home BP readings should be used to determine true BP and that non-pharmacologic methods of lowering BP should be used before medications. You can find a summary of the guideline by clicking on “guideline change” above. **Be informed, and then discuss BP with your primary care doctor.**

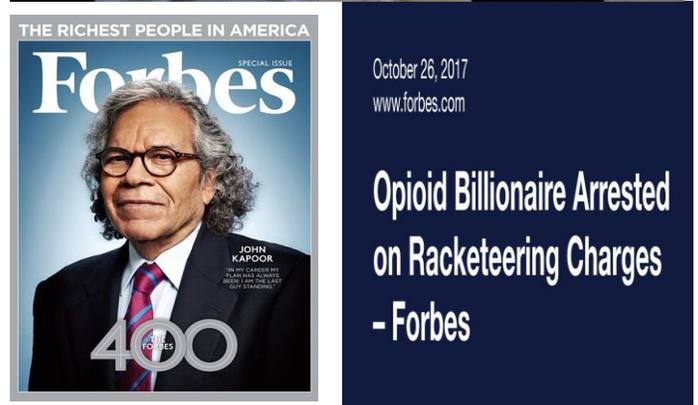
Who Is Accountable for the Opioid Epidemic?

In our complex and disorganized health care delivery system, there should be no surprise that there are several factions to blame for the opioid epidemic. A couple of lawyers wrote about [legal perspectives](#) involving accountability in the *New England Journal of Medicine*. Blame must fall on individual physicians who over-prescribed opioids, pharmacies that dispensed excessive amounts of opioids, and on the distributors who pushed opioids

into communities in amazing amounts. The lawyers focus on the last bunch for accountability.

They describe the ways the government is going after the distributors. Legally, will efforts to prove opioids are defectively designed work? Probably not, they write. One issue here is that drug makers have only to notify prescribers of the risk of opioids, not patients. If physicians do not warn patients, then no one does. Another legal approach is to assert that groups of people have been harmed by the drugs. A promising approach here is the harm to babies with newborn abstinence syndrome. I’ve talked to people who have witnessed this and it is a heart-wrenching syndrome.

Did makers and distributors fail to control misuse of the drugs, engage in deceptive business practices, or deceive the public about addiction – perhaps not. The most promising legal approach for accountability may be the cost to governments of the opioid epidemic in the face of deceptive business practices.



Unfortunately, in my opinion, the medical industry is fraught with deceptive business practices. This is a natural consequence of an industry in which vulnerable patients can be sold far too much “care” in the interest of making money. Patients’ needs are too often secondary to revenue generation. Until individuals are held criminally liable for

patient harm caused by deceptive business practices, there will be no stopping harm to patients. The answer to the question posed in the title of this summary is “no one.”

Guidelines for Treatment of Seasonal Rhinitis

A [guideline](#) for care of those with seasonal rhinitis has been released by a presumably cognizant and unbiased group of experts. The guideline is broken into 2 basic parts. Part 1: for those 12 or older, initial treatment should be with an intranasal corticosteroid alone (no oral antihistamine or leukotriene receptor antagonist). Part 2: For persons with moderate to severe allergic rhinitis, add an oral antihistamine to the intranasal corticosteroid. The first recommendation was based on strong evidence and the latter on weak evidence. Go figure.

Compounding of Drugs

You may remember the harm and 76 deaths caused to Americans who received an injection of a fungus-contaminated drug from a [compounding company](#) in New England. That company has since been closed and the lead pharmacist and company owner convicted of mail fraud and racketeering, but not of murder. Do not suppose that problems with compounding companies has been solved. Two female physicians voice their concerns that too many doctors are prescribing [compounded formulations](#) to deal with postmenopausal symptoms rather than FDA-approved drugs.

The reasons clinicians choose to prescribe the compounded drugs may be the belief that a woman is getting something customized for her, or the mistaken perception that the compounded formulation is natural. The doctors point out multiple ways compounded drugs may prove riskier, especially the lack of any effective regulation and the lack of a package insert warning women of the risks. FDA-approved drugs have package insert outlining risks. The writers call for laws requiring a package insert and for improved FDA regulation of compounding pharmacies. They declare that in the

absence of such laws, clinicians must tell their patients the truth.

Risks of Overlapping Surgeries

A huge team of MDs asked about increased risk to patients of [overlapping surgeries](#). This was defined as the attending surgeon performing two surgeries within 30 minutes of each other. The retrospective study included 38,000 people undergoing hip surgery, and a second group of 53,000 undergoing hip arthroplasty in Ontario, Canada from 2009 to 2014. Respectively, 2.5% and 3% of the surgeries were overlapping. The risk of complications from overlapping surgeries was 85% and 80% higher, respectively in the two groups when compared to non-overlapping surgeries. In addition, the investigators found that longer lasting surgeries were associated with more complications. **The lesson for patients is that you must request that your surgeon not perform your surgery at the same time as he is operating on someone else.**

Useful Patient Pages

Polypharmacy:

<https://jamanetwork.com/journals/jama/fullarticle/2661582>

Hepatitis B vaccine:

<http://annals.org/aim/fullarticle/2664090/hepatitis-b-vaccination-screening-linkage-care>

Active surveillance for prostate cancer:

<https://jamanetwork.com/journals/jama/fullarticle/2665002>

Find past newsletters:

<http://patientsafetyamerica.com/e-newsletter/>



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Answer to question: Actual number 78.6, so (d) and (e) are equally correct. Source:
<http://www.cnn.com/2017/12/21/health/us-life-expectancy-study/index.html>