Patient Safety America Newsletter

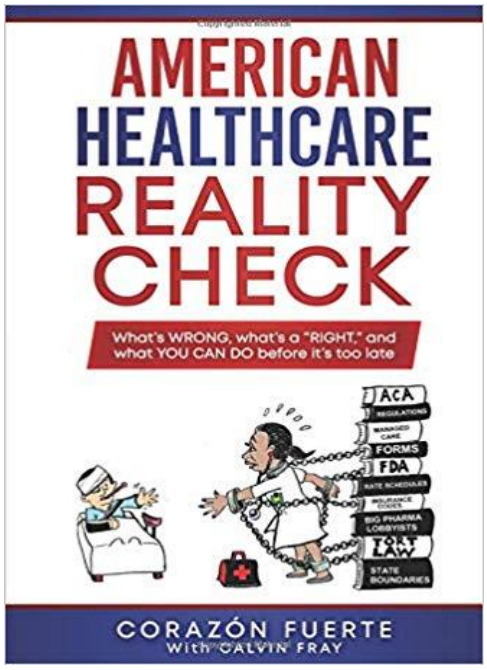
February 2019 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: What fraction of 14,000 U. S. nursing homes had lower staff-to-patient ratios than reported to the federal government? a) 1 in 10 b) 3 in 10 c) 5 in 10 d) 7 in 10 e) 9 in 10*

Book Review: **American Healthcare Reality Check**

By Corazon Fuerte, with Calvin Fray

Ms. Fuerte (not her real name) is a life and health insurance agent living in California. She does not wish to disclose her identity for fear of retaliation. Interesting. She describes her book as a "productive outlet for her feelings." It is divided into three parts: 1) What is wrong with our healthcare, 2) What is - and is NOT - a "right" with healthcare, and 3) What you (and we) can do NOW – before it's too late. Her style is unusual in that a topic is declared in large bold letters, and this is followed by a "stream of consciousness" series of separated sentences or short paragraphs. The relationship between topics is not always apparent.



In the interest of disclosure, I was pleased that the author used material from a book I co-edited called *The Truth about Big Medicine* and cited my study in the *Journal of Patient Safety*. I certainly agree with many of her sweeping concerns about problems in our broken healthcare non-system. For example, I agree that too many babies are born to parents that have no intention or means of becoming responsible parents, our healthcare cost at $10,000 per person per year is not affordable, we have problems with suicides and lack of mental health support, and the adverse effects of medications harm too many folks. She wades into political waters with her views on gun control. On this topic, she is naïve.

She is right about too much secrecy, but I think she is wrong about single-payer medical systems. These work well in many other developed countries. When she wanders into the realm of personal rights, her views are not balanced. She views the idea that everyone has a right to healthcare as being in conflict with the right of medical professionals to govern who they treat. Treatment is rendered by parting with some of their right to control their lives if forced to do treatment. Ethicists would disagree with her view on abortion being allowable until the fetus is viable outside the womb. A final example troubled me. She took on vaccines on the basis of their content of heavy metals. As a toxicologist, I know that "dose makes the poison." It is quite easy to scare people with the "heavy metal" charge, but the only thing that matters is the dose and form of the heavy metal.

I'll give Ms. Fuente 5 stars for taking on some challenging and controversial healthcare topics. I'll give her 3 stars for sometimes failing to give a balanced perspective, and making a few technical errors when taking on complex scientific issues. She offers some practical solutions that her readers may act on to manage their personal healthcare risks and contribute to changing our broken system. 4 stars. About $14 in paperback. The book is definitely worth this modest price.

Should You Take Statins?

A few months ago there was a groundswell of news about the idea that massive numbers of Americans should be taking statins to protect against cardiovascular disease. This astonishing call stemmed from new guidelines extolling the value of taking these drugs. Because of well-known adverse effects of these drugs, some were not too sure about the hysteria to use these drugs. A modeling study just published in the *Annals of Internal Medicine* matched adverse effects (muscle disease, liver disease, and diabetes) against positive effects, finding that age, sex, and type of statin determine whether there is a net benefit from taking the drug. It's complicated.

To begin with, one must calculate their cardiovascular risk. This may be done at the following site: https://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/heart-disease-risk/itt-20084942. You will need to know your height and weight, your cholesterol and LDL numbers, your history of heart problems, your blood pressure numbers, and your diet and exercise habits. The result is your 10-year risk of "heart disease." The site also lets you know how much lower your risk could be if you were to control those factors that are controllable. Armed with that number, let's see how you fit into the results of the modelling.

Remember that the higher the number, the less likely you are to benefit from taking statins. Below is a table I created from figure 1 of the paper. If you are a 70-75 year-old male, you should have a 21% risk of a cardiovascular event over the next 10 years before it would be deemed marginally beneficial for you to take a statin. The present guidelines call for treatment at either 7.5% or 10% regardless of age. A couple of MD editorialists explained why the new findings differ so much from the guideline estimates. This primarily has to do with how the adverse effects were considered. The guidelines took a simple, limited approach, whereas, the new estimates use a wider scope of adverse effects that tip the balance toward less use of statins. Four statins were evaluated. The best were atrovastatin and rosuvastatin. The editorialists indicate that the data should be explained to each patient and the patient's preference elicited. In any case, if you want to eliminate a statin prescription, discuss this new finding with your physician.

Age Range in years	Male, 10-year risk (%)	Female, 10-year risk (%)
70-75	21	22
65-69	19	21
60-65	18	20
55-59	16	19
50-54	15	18
45-49	14	18
40-44	14	17

Who Manages Your Diabetes

In many settings, primary care is being delivered by physicians, nurse practitioners (NPs), and physician assistants (PAs). It's reasonable for patients to be concerned that the less-trained NPs and PAs may give lower quality care. A large team of experts asked whether care of diabetics being treated with drugs in the Veterans Administration (VA) hospitals varied depending on the training of the primary clinician. The investigators looked at records from 568 VA hospitals covering 368,481 patients being treated for diabetes (mostly males). They assessed three outcomes as follows: HbA1c, systolic blood pressure (SBP), and low-density lipoprotein (LDL-C). They compared results based on the type of primary care provider seen most often by patients in 2012.

On average, all of the outcome variations were very small. Compared to physician care, the average differences were as follows: for **HbA1c**, NPs -0.05%, and PAs +0.01%; for **SBP**, NPs -0.08 mm Hg and PAs +0.02 mm Hg; and for **LDL-C**, 0.01 mmol/L and PAs +0.03 mmol/L. The authors note that their findings indicate that "similar chronic illness outcomes may be achieved by physicians, NPs, and PAs." Limitations in attempting to generalize the results include the older-sicker population treated in the VA system, the possibility that NPs and PAs consulted off the record with physicians, and that more team-based care was practiced in VA hospitals.

Opioid Overuse and Suicide

The statistics on suicide and opioid use are alarming for the U.S. According to a review article in the *New England Journal of Medicine*, the number of deaths from suicide and unintentional drug overdose increased from 41,000 in 2000 to 111,000 in 2017. More than 40% of the deaths due to suicide and unintentional overdose in 2017 involved opioid use. The use of opioids increased dramatically in the early 2000s due to regulatory calls to aggressively manage pain. The average prescribed dose of opioids from 2000 to 2007 increased from 100 to 700 morphine milligram equivalents per person per year. Two basic hypotheses have been proposed to explain the increasing rates of suicides and overdose deaths.

The first hypothesis relates to despair increasing in white middle-class men as opportunities for success have declined for the working class. Opioids may be a way to deal with the stress of lack of opportunity. This leads to depression and the risk of suicide. The second hypothesis involves the increasing availability of opioids, often outside legal supply channels or through overprescribing. It seems to me that both hypothesized causes are likely at work, perhaps in different portions in different parts of the United States. For example, Houston has plenty of good jobs for people in the working class, whereas parts of Appalachia and the "rust belt" do not. Some of the most direct targeting of opioid oversupply was aimed at Appalachia, but we certainly had a few pill-mill doctors in Houston.

A fascinating article in the same journal drew parallels between the HIV epidemic of the 1990s and the opioid epidemic presently before us. We now have effective medication-assisted treatment (MAT) for opioid addiction, just as there were effective treatments coming on line in the 1990s for HIV infection. The writers note that even now, viral suppression has been achieved in only half those with HIV infection. There are 4 facets to doing better with opioid addiction.

The first facet is eliminating barriers to addicts actually seeking care for their illness. These include social barriers that divide advantaged people from the poor. Secondly, we must change the cultural structures that facilitate growing dependence on opioids. This includes market-driven healthcare. The third facet of delivering care is to demolish any stigma associated with opioid addiction. The fourth component is to mobilize family and communities to support those with opioid addiction. Finally, the authors postulate that there may need to be activism, such as that which happened during the HIV epidemic to make MAT widely acceptable. The idea of using "medications" to treat an addiction may be unacceptable to those who do not understand the recidivism of those not on medications.

Stopping "Conveyor-Belt" Medicine

An interesting perspective article by 2 MDs makes valuable reading for patients and their advocates. It's a story that may apply to many as the ravages of ageing seize us. A 70-year-old man has been transferred to a larger hospital because it has been discovered that his aortic aneurism is under threat of rupture. The conveyor belt is readied as the transfer begins. The images suggest that this is not going to be a simple operation – there had already been an operation to contain the aneurism some years ago. As the conveyor belt rumbles along, someone suggests that the patient's wishes need to be discerned. This is not possible because he has serious dementia, and is not able to understand or communicate his preferences. He lives in a nursing home where he fills each day by walking the premises, stopping only to eat and sleep. After a consultation with his family, the decision is made to do nothing. If there is anything to be given to him, it would be a new pair of sneakers. The story ends with the observation that 6 months after the conveyor belt was stopped, the man still walks all day in his home. He is content.

This story conveys the truth that at some age in our lives we simply want to be left alone to allow nature to deal with us as she might. Far too much money is wasted near the end of our lives on futile medical interventions. Unfortunately, as the end approaches, we may be incapacitated as the gentleman in our story was. Discovering our preferences may be a challenge. That is why we must be nice to our children.

Your Physical Conditioning

How are you doing with your new-year resolutions to get healthier? New guidance has just come out on physical activity needed to achieve optimal health. This may be summarized as follows:

- Children 3-5 should be physically active all day
- Children/adolescents should do 60 minutes of moderate to vigorous activity daily
- Adults should do 150-300 minutes per week of moderate-intensity exercise
- Adults could, alternatively, do 75-150 minutes per week of vigorous exercise
- Adults should do muscle strengthening exercises at least 2 days per week
- Older adults should add balance training to their strength and exercise regimens

The writers note that simply moving much during the day is helpful compared to sitting all day. Moderate-intensity exercise includes walking at 2 ½ to 4 mph, playing volleyball, or raking leaves. Vigorous-intensity exercise includes jogging, running, carrying heavy groceries, or a vigorous exercise class. Riding a bicycle or swimming may be either, depending on the energy expended to perform the exercise. You may download the entire exercise guideline book at the following site: https://health.gov/paguidelines/second-edition/. It's 14 MB. I like walking through woods for exercise, although there are reports of coyotes in the woods I enjoy. I may have to suddenly convert from moderate to vigorous exercise.☺

National Effort to Reduce Cardiovascular Disease

Since 2012 there has been a concerted national effort to reduce the number of hospital admissions for cardiovascular events (heart attack and stroke). The effort focuses on reduction of sodium consumption, exercise improvements, taking aspirin where appropriate, controlling cholesterol, managing high blood pressure, and stop smoking. Success has been modest. The authors of a viewpoint article note that there are 213 million opportunities to mitigate the risks associated with these targets. They arrived at this estimate by adding up the number of adults that are not taking appropriate aspirin (9 million), have uncontrolled high blood pressure (40 million), not taking a statin (cholesterol reducing, 39 million), smoking (54 million, and lack appreciable exercise (71 million). So if you are one of these folks with unnecessary cardiovascular risk, you have a target on your back.

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NATIONAL QUALITY FORUM
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PATIENT PAGES
Benefits and harms of statin use
Effectiveness and safety of bariatric procedures for weight loss

Answer to question: d) 7 in 10, reference: https://www.pbs.org/newshour/health/most-nursing-homes-are-not-adequately-staffed-new-federal-data-says?fbclid=IwAR1NBeSW0vEBD9gncQE0hGHPU5jDN5lU01xZQc2z4JJvmje8qMGyGwLyyE8