

**Question:** According to the Centers for Disease Control and Prevention, how much did surgical site infections decrease from 2017 to 2018? a) none b) 5% c) 10% d) 15%

## Generally, Well Tolerated – Deceptive Drug Language

If you read the book I reviewed last month entitled *The Price We Pay*, you know that deceptive language is not uncommon in medicine. Three experts addressed the [language](#) used by those who evaluate drugs for their toxicity. One example they cited chronicles the testing of a chemotherapy drug for metastatic colon cancer. During the testing, the therapy was discontinued in about 30% of the test subjects and 13 died. The investigators declared that ‘the treatment was well tolerated.’ The experts Google-search discovered 50,000 medical articles published since 2000 in which the treatment was described as ‘generally well tolerated.’

The article writers call for improved communication from investigator to physician to patient. Language that ‘glosses over’ adverse toxic effects must go. They call for language that is more characteristic of the results. This might include the percentage of participants that experienced mild to moderate effects. For sicker patients the result may be characterized as ‘manageable’ with percentages assigned to some of the more serious effects. If patients die from treatment, then this must be made clear to those considering the drug. Most of us know people that more-or-less recovered from their illness, but they describe the side effects of chemotherapy as much worse than they expected.

**The wise patient will ask for more in-depth information when the answer to their question about toxicity is brushed aside with a vague description. Ask for copies of the studies of the drug proposed for your treatment. Maintain control of your right to decide what is and is not done to your body. Insist on quantitative knowledge about side effects and expected outcomes. Ethicists call this autonomy.**

## Diabetes Linked to Diet

A large team of [investigators](#) associated with various Harvard University medical departments performed a Meta-analysis on 9 observational studies that involved dietary information and the incidence of diabetes in the populations studied. The combined populations numbered about 307,000 of which 24,500 had adult, type-2 diabetes. Those adhering to a plant-based diet were roughly 23% less likely to have diabetes than those not adhering to such a diet. When healthy, plant-based foods were consumed, the risk of diabetes dropped 30% from the non-adherent group. The healthy food list: fruits, vegetables, whole grains, legumes and nuts.



The mechanism of this apparent protective effect probably involves higher consumption of foods rich in vitamins, minerals and antioxidants associated with plant-based diets when compared to diets with more red and processed meats. The authors report that their findings are consistent with those involving a Mediterranean-type diet. Given the high incidence of type 2 diabetes in the U.S. and the high cost of drugs used to treat this disease, one might suppose that some public-service announcements would be forthcoming from the government on how dietary choices affect one’s risk of various diseases, including diabetes.

## Speaking of Expensive Drugs for Medicare Beneficiaries

Two experts, [writing](#) in the *New England Journal of Medicine*, address the need and means for the government to be able to negotiate lower drug prices for drugs used by Medicare beneficiaries. The rules governing negotiations between Pharma and the government tilt in favor of Pharma. This stems from relatively powerless, fragmented insurers negotiating against powerful, monopolistic drug sellers. If a drug is administered by a clinician, then under Part B rules, there is no negotiation. Given the targeting of developing specialty drugs with attendant monopolies, the future is not promising for any relief.

Among several possibilities to balance drug prices, the authors propose using an effectiveness index to establish the price the government will pay. This could be tied to the Quality-Adjusted Life Years gained by use of the drug. The authors recognize that their proposals may generate an impasse between the government and makers of specific drugs, in which case an unbiased arbitrator would enter the picture.

Frankly, I like the idea that was not expressed in the article of tying drug prices to those paid in other developed countries. For example, Medicare under appropriate rule changes, might simply declare that it will pay no more than 10% above the average price paid by OECD (Organization for Economic Cooperation and Development) members, or it will start buying drugs from other countries with lower prices.

If you care about lower drug prices, then complain to your congressperson about the impact of high drug costs on your personal budget. Note also that it is *your* money going into Medicare that is being used to subsidize Pharma, and that you do not think that is a reasonable use of *your* money. You might wish to know that American pharmaceutical companies spend about \$200 million each year lobbying Congress ([CNN \\$\\$\\$\\$](#)).

## Waste in American Healthcare

Three experts writing in the *JAMA* set out to provide a new [estimate](#) of the waste in the U.S. healthcare non-system. Past estimates have been about 30% waste. They looked at a collection of recent studies addressing 6 healthcare domains as

follows: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity. The potential, annual savings in each of the first 5 domains ranged from \$13 billion to \$91 billion. Something like \$230 billion could be saved by reducing administrative complexity. The overall potential savings was about \$850 billion per year.



In my opinion, this huge amount of waste is a result of weak regulatory oversight, an industry focused on medical interventions rather than personal health, intense lobbying by the healthcare industry, a for-profit model of much of healthcare, and citizen complacency. **You cannot do much about the first 4 issues, but the last one is in your hands. Write your congress-persons demanding that they do something to constrain the escalating cost of American healthcare. Tell them you are committed to supporting candidates that take this problem seriously and have workable solutions.**

## The Means of Reducing Waste in Healthcare

Two MDs, [reviewing](#) the study of waste in American Healthcare, commented on the ways that things could change to reduce waste. They write their way through a collection of 6 possibilities, concluding for the most part that none of them are going to do much to reduce waste in American healthcare. These included the following: value-based payments, reductions in administrative reporting diversities, shift away from fee-for-service models, get physician buy-in for reforms, reduce costs associated with implementation of reforms, and improve information on hospital costs and quality of care. The authors opine that, collectively,

these strategies may make the measurement of healthcare waste a bit lower the next time it is taken.

I am of the opinion that empowering patients, which is partially behind some of these plans, will do the most for change. The study my [colleagues and I](#) published a few months ago show that a reasonable patient wants to use decision aids and know beforehand what his out-of-pocket-costs are going to be. In half the states, the wishes of a 'reasonable patient' define the content of informed consent. At the federal level, informed consent for all patients in Medicare and Medicaid should require that clinicians provide the information that a reasonable patient wants to know. This would happen in the framework of shared-decision making (SDM) for specific cases.

Beyond this, a federal law, superseding any state laws on informed consent, should make patient-centered informed consent a requirement. The clinician-based standard for informed consent in half the states must be thrown out. There should be one law of the land. Fully informed patients that have been involved in SDM are likely to generate a substantial reduction in medical costs because they will choose less invasive (expensive) procedures, drugs and devices. And, they will live longer.

### **World Health Organization on Nutrition**

Nutrition is a problem in most developing countries. Some of my life experiences, especially my mission trips to Haiti and Ecuador, have made me acutely aware of nutrition problems in developing countries.



A report just issued by the WHO targets solutions to health problems in developing countries ([WHO](#)). In past newsletters I have discussed nutrition problems in the U.S. including the elderly, those in hospitals, and those consuming too many calories. The WHO nutrition report targets include the following: decrease the number of children with stunted growth, reduce anemia in women of child-

bearing age, decrease number of low-birth-weight infants, reduce deaths from heart disease, cancer, diabetes, and respiratory illness, and reduce blood pressures. The reason I list these targets is to show the huge impact poor nutrition can have on the incidence of many health problems.

In the "Essential Nutrients" action plan, WHO listed the following: reduce the ingestion of free sugar, increase intake of potassium, reduce the intake of sodium, and restrict fats of various types. In addition, the WHO recommends 5 portions of fruit and vegetables per day. I think that is all good advice for we Americans. I am going to recommend an organization called Southern Institute for Appropriate Technology (SIFAT, also Servants in Faith and Technology). I have seen firsthand the work it does, and I know its roots are in sustainable improvements in developing countries. One of its main goals is to improve nutrition. If you wish to see more about SIFAT, please visit [SIFAT](#).

### **Medicaid Expansion. Does it Work?**

The vast majority of states have expanded Medicaid coverage to the working poor. Many have had coverage for 5 or more years, so the time is right to assess whether such expansion has resulted in health improvements. A couple of experts [surveyed](#) the literature on this subject and expressed their viewpoint in the *JAMA*. Self-assessments of health and well-being improved for those gaining Medicaid coverage. In disease-specific studies, benefits have been seen for those with end-stage kidney disease, aortic aneurysm, and acute appendicitis, among other diseases. There was no demonstrable in-hospital mortality improvement for people with congestive heart failure. Overall, the authors conclude that Medicaid expansion has been successful. The abiding question is whether the monetary costs of this expansion could have been used in better ways, such as social services or direct funding to safety net hospitals.

### **Do Antipsychotic Drugs Prevent Delirium?**

Antipsychotic drugs are often used to reduce delirium following surgery. Delirium is a risk factor for harmful outcomes, including death. A [team of investigators](#) surveyed medical literature to determine the level of evidence supporting this practice. Their search identified 14 random control

trials that each found no improvement in the risk of delirium when antipsychotics are given to patients. They note that their collection of studies was heterogeneous in terms of medications used, dosages, and assessment of outcomes.

I have had direct experience with Haldol and Seroquel, both antipsychotics. These drugs were given each evening to my father to control his ‘delirium’ at night. After 8 days of administrations of one or both of these, there was noticeably worse ‘delirium,’ so we demanded that these drugs be discontinued. His night-time behavior improved greatly. He had to sign a form declaring that he refused treatment. The obvious failure of the drug to help him was not sufficient data for the physician to discontinue the drugs.

### Physician Burnout and Quality of Care

Three experts expressed their [view](#) that the association between physician burnout and quality of care has yet to be fully settled. They point out that there is lack of consistency in how to assess physician burnout; moreover, measures of care quality are highly heterogeneous. In the end, the experts conclude that there is good evidence that physician burnout and lower quality care are associated; however, we are left without answers about the magnitude of the association and the effect on patient outcomes.

### Pharma Buying Prescribing Influence

Five experts asked about whether Medicare spending from 2014 to 2016 on 2 drugs prescribed by gastroenterologists to treat inflammatory bowel disease was [associated](#) with drug manufacturer payments to the doctors doing the prescribing. As you might guess, there was an association, although the scatter-grams are noisy. For each dollar paid by the manufacturer of adalimumab to doctors, there was a \$3.16 increase in spending by Medicare. For each dollar paid by the manufacturer of certolizumab there was a \$4.72 increase in spending by Medicare. The authors caution that they found

only an association, not a cause and effect. For the patient this all leads to the question of whether one can know whether there is the possibility of perverse incentives when receiving any treatment.

### Finally, Harms and Costs in a Guideline

Hematuria (red cells in one’s urine) may be readily found through urinalysis, which is cheap. However, new guidelines do not support using this as a screening tool for urinary tract cancer in asymptomatic persons. The authors support [guidelines](#) that stand against applying CAT scans of the urinary tract to discern the cause of blood in the urine; CAT scans often follow discovery of hematuria. One reason against CAT scans following hematuria is that CAT scans themselves elevate the risk of cancer, so the clinician must make an intelligent recommendation about which patients need this expensive test. There are other ways; ultrasonography, which is non-invasive and relatively cheap. The authors, three MDs, list the harms of evaluating hematuria – false positives, radiation-induced cancer, incidental (meaningless) findings, overtreatment, time wasted, and cost to patient and the healthcare system. They support new guidelines that consider the harms and costs of over-screening when the patient is asymptomatic.

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**Answer to question: a) none, reference:** <https://www.cdc.gov/hai/data/portal/progress-report.html>