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<http://PatientSafetyAmerica.com>

John T. James, Ph.D.

Question: Per person, how much do Americans spend on healthcare administrative costs per year?
 a) \$500 b) \$1,000 c) \$1,500 d) \$2,000 e) \$2,500 f) \$3,000 g) \$3,500

Book Review: Code Blue – Inside America’s Medical Industrial Complex
 By Mike Magee, MD

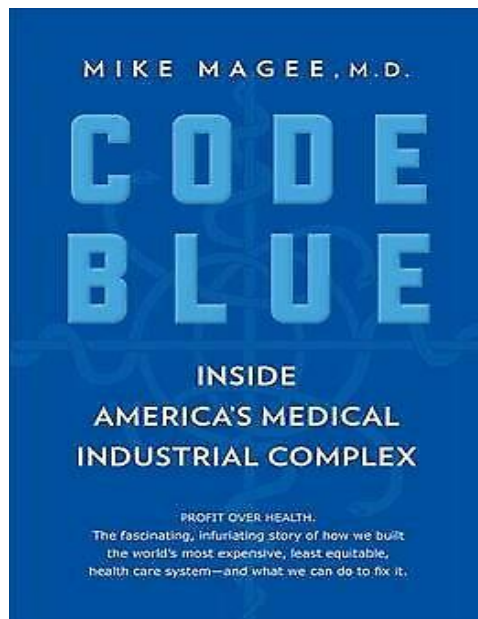
‘Code Blue’ is the term used for hospital announcements from the public address system that a medical emergency requires immediate attention. Dr. Magee used this title to indicate that the American health care system is in critical condition. He has worked in what he calls the Medical Industrial Complex (MIC) most of his career, primarily in the pharmaceutical industry. He adds another book title to those of other MDs that have been critical of American health care. These include the following: *Death by Prescription* (2003), *The Truth about the Drug Companies* (2004), *Fatal Care* (2008), *Flatlined* (2009), *How We Do Harm* (2011), *Overdiagnosed* (2011), *Unaccountable* (2012), *An American Sickness* (2017), *Why We Revolt* (2017), *I Didn’t Know I Didn’t Know* (2018), and *The Price We Pay* (2019). *Code Blue* is a unique addition to this collection that should warn every patient to be extremely careful when seeking health care. Too many patients have told me they trusted, and that was a big mistake.

Dr. Magee expends many pages on the history of how the American health care system came to be in critical condition. In terms of theology, it is a system that has lost its soul. The soul of healing the sick has fallen to the idol of capitalism. He spares few elements of the American system

in pointing fingers. He attacks Pharma, the American Medical Association, the Joint Commission, hospitals, the health insurance industry, bought medical scientists, purchased patient-advocate organizations, biased government regulatory agencies, conservative religious factions, and clueless politicians.

The historical roots of how we came to have the most expensive and least effective health care industry among developed nations are interesting. At times, Dr. Magee may be a bit tedious as he weaves personalities that together focus on clever ways to make every dollar that they can make with no regard for the harm they cause to ordinary people who are especially vulnerable. He addresses the unfortunate mantra of American health care, which is that more money is made in repairing the sick than in keeping people well.

In his last chapter, Dr. Magee, compiles a list of areas that need reform, to include medical education, clinical research, medical publications, and marketing. He also provides a 10-point list that makes the case for a single-payer health care system. I’d not say that his reforms are comprehensive, but they would take a lot of the bullshit out of the current way the Medical Industrial Complex operates. This book will help the dedicated reader understand how we could repair our misguided healthcare non-system. It will be a daunting task to reverse the forces of greed. 4 ½ stars. About \$15 on Amazon.



Benefits of Intermittent Fasting

Two PhDs write elegantly about the mechanisms involved in [intermittent fasting](#) with beautiful illustrations of how this happens biochemically in our bodies. The illustrations are masterpieces of art and pathways. They conclude with a figure suggesting the steps necessary to elicit the extensive health benefits of intermittent fasting.

Primarily from studies in animal models, investigators have shown positive effects of intermittent fasting on obesity, diabetes, cardiovascular disease, cancer and neurodegenerative diseases. The ‘flipping’ of the metabolic switch between a fed state and a fasting state causes improved glucose handling, improves stress tolerance, and reduces inflammation. The authors posit that this mechanism is a ‘gift’ of our evolutionary heritage. If we were to survive times of sparse food, we had to be prepared to handle the situation metabolically. Basically, in the fed state the animal or person uses the newly ingested fuel (food) to stay alive, whereas, during a fasting state, adipose tissue is burned.

The barriers to doctors suggesting intermittent fasting to patients are substantial. First, we are conditioned to eat 3 meals and snacks each day – every day. Food is readily available in developed countries, so avoiding the temptation to eat almost continuously in our waking hours is ever-present. As one dives into intermittent fasting, there is a tendency to become grumpy. There are people in my family that become extremely grumpy late in the afternoon, but a high-calorie snack transforms Mr. Hyde to Dr. Jekyll, as if by magic. The authors note that this problem fades during the first month of intermittent fasting as one’s metabolism adapts to times of not-food. Another problem is that physicians are not trained to discuss this lifestyle change with patients. They may not be prepared to provide the necessary support as patients begin intermittent fasting.

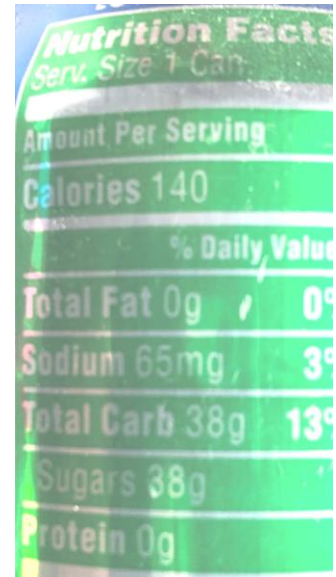
What does intermittent fasting look like? One approach is to drop one’s ‘feeding period’ from 10 hours per day, 5 days per week, to 6 hours per day, 7 days per week in monthly increments. Another approach is to restrict calories progressively each month from 1000 calories, 1 day per week to 500 calories 2 days per week. The writers suggest that in the final month of these plans, the patient

should be monitored for any adverse effects. My current experience is that a 10-hour feeding period, 7 days per week is not that burdensome; however, I’ve noticed that during my ‘feeding period’ I tend to eat more than I should, especially chocolate. The positive effects, after 2 weeks on my weight and waistline have yet to be experienced. **If you are motivated to try intermittent fasting, ask a professional to assist your efforts. Since the article I summarize is behind a pay wall, visit your local library to see if it keeps a subscription to the *New England Journal of Medicine*. Read the article. Act.**

Ban Sugar-Sweetened Beverages (SSBs)

A large team of [investigators](#) asked whether banning SSBs in the workplace would elicit an effect on worker’s waist line, and whether a support intervention had any additional effect. The study involved 214 participants with an average BMI of 29 and average age of 41 years. They were high consumers of SSB (about 35 oz. per day). The study lasted 10 months and the nominal reduction in SSB was about 50%. The intervention dramatically cut SSB consumption further.

For participants with a BMI above 25, the decrease in average waist circumference was just over an inch, apparently without the need for brief intervention. There was no reduction in average BMI or positive changes in metabolic outcomes. One serious limitation was that the SSB consumption was self-reported. There was also not a rigorous control group located at another workplace. None-the-less, these findings are interesting from the perspective of ‘lead us not into temptation.’ If the calories are difficult to get, then maybe we will consume fewer of them and become at least a bit healthier. I’d also ask about the availability of beverages sweetened with artificial sweeteners. Did consumption of these beverages increase when the SSB were removed? Consumption of beverages containing artificial



sweeteners has been worrisome in the past, but it seems that such concerns have been allayed ([diet drinks](#)).

Dangerous Dietary Supplements

Many of us consume dietary supplements, assuming someone along the line has verified that the product we put in our body is safe. Don't believe it! An MD and JD wrote their opinion of current [protections](#) for consumers of dietary supplements, and it is troubling. The law that was intended to protect the public from dangerous supplements was implemented in 1994, but since then the manufacturers of supplements have found clever ways around the law by slipping through loopholes. Concomitantly, the FDA has failed to enforce the law. Of the roughly 75,000 supplements introduced since 1992, a whopping 250 have adequate safety data.

The authors cite the example of a stimulant introduced to energize the consumer and elicit some weight loss. The Department of Defense soon banned it due to the risk of hemorrhagic stroke. One company replaced this stimulant with another that led to an outbreak of 'severe hepatitis.' The authors call for mandatory submission of ingredient labels to the FDA. Any new ingredient must have safety data provided, and the FDA should do its job of enforcing the law to ensure ingredients are safe. The latter will require additional funding.

In the meantime, be cautious with consumption of any dietary supplement. Ask yourself if the imagined gains from the supplement outweigh the potential risks of consuming a chemical that may have little to no safety data available.

Non-Conforming Electronic Health Record (EHR) Systems

There is a certification process for vendors of EHRs and associated products. Surveillance is conducted by the DHHS Office of the National Coordinator. This happens through random surveillance and reactive surveillance when something is suspect. Three investigators asked how often [surveillance discloses](#) potential harm from non-conforming EHR product vendors. Overall, they found that 3.7% of the vendors failed to comply

with certification standards. This may have contributed to patient harm.

The researchers did not give an example of potential patient harm but allow me to speculate. Because of the plethora of EHR types, there is a robust industry addressing interoperability between various systems. If some vendors 'magic' device for doing this mistakenly translates units on an important clinical measure, then that would be a potential for contributing to patient harm. **The lesson here for patients is to carefully monitor your EHR for mistakes, whatever their source. This is especially important when you change healthcare systems and transfer your records.**

Atrial Fibrillation (AFib) and Alcohol Consumption

An [editorialist](#) took the opportunity to discuss the lifestyle causes of AFib and discuss the findings of a recent study from Australia involving moderate consumers of alcohol and better control of AFib. AFib is associated with increased risk of stroke and death. Its incidence is expected to increase in the future as the population ages and becomes more sedentary. Important risk factors for AFib include high blood pressure, type II diabetes, and sleep apnea.

The new study used 2 groups of 70 drinkers (16-17 standard drinks per week) with AFib, asking one group to abstain from alcohol consumption and the other to act as controls. The 'abstainers' reached an average of 2 drinks per week, whereas the controls dropped to 13 drinks per week on average. Over the 6-month investigation, the abstinence group lost almost 4 kg and experienced lower blood pressure. AFib recurred in 53% of the abstinence group and 73% of the control group. The editorialist points out that this was a small study involving mostly men and that the participants had a low frequency of AFib.

I would have added electrolyte issues (especially low potassium and magnesium) to the causes of AFib. It is well known that electrolyte [imbalances](#) contribute to the risk of AFib. The editorialist points out that abstaining from alcohol may not be a viable solution for many with AFib. If you have AFib that affects your living, then ask your doctor for ways to manage it. There are many non-

invasive ways to reduce the frequency of AFib and, thereby, the risk of stroke. Invasive actions, such as anticoagulants and cardiac ablation should be a last resort.

Patient Harm from Medicare Fraud and Abuse

Medicare tries to discover and punish fraud and abuse, which it defines as ‘any practice that, either directly or indirectly, results in unnecessary costs to the Medicare program.’ It is estimated that such practices cost the program between \$30 and \$140 billion per year. A team of four [investigators](#) asked whether the care provided by fraud and abuse perpetrators (FAPs) between 2013 and 2015 was substandard before they were caught. The outcome measures were more ER hospitalizations and higher mortality. The team looked at outcomes in the 3 years before the FAP was identified. This is no small problem; in 2018, 47,000 professionals were barred from participating in federal healthcare programs. These were physicians, nurses, and aides.

The investigators found that more harm came to patients that had been treated by FAPs than those treated by non-FAPs. For patients treated by fraud-FAPs the mortality rate was 4 % higher than those treated by non-FAPs. For ER hospitalizations, the fraud-FAP-treated patients had a 3.3% higher rate. The investigators also looked at patient-harm FAPs and revoked-license FAPs. Clearly, Medicare fraud and abuse not only costs the system money, it causes substantial patient harm. The investigators recommend permanently removing FAPs from the Medicare program. It’s up to your state licensing boards to determine if the professional can continue to practice in their state of residence.

Food Insecurity of Medicare Beneficiaries

The U.S. Department of Agriculture has defined food insecurity using six factors: has your food ever run out, have you had no money to get more, were you unable to eat balanced meals, did you reduce or skip meals, did you eat less than you should, or were you hungry due to lack of money. A

[team of investigators](#) looked at 9,700 responses of Medicare beneficiaries covering 12 months, using the benchmark that any 2 of the 6 above constituted food insecurity.

They discovered that about 9 % of beneficiaries experienced food insecurity by their definition. The subset of those beneficiaries, those on Medicare due to disability (not because they are 65 years old or older), reported a 38 % rate of food insecurity. The sample population represents 50,700,000 beneficiaries, so the number of people with food insecurity in the U.S. is about 4 ½ million. These findings are important because they shine a light on the failure of the American healthcare system to place emphasis on a key element of health – enough nutritious food to eat. Low income groups had more frequent food insecurity, as one would expect.

I’d suggest that if you have an elderly or disabled friend with limited means, then you should ask from time to time about their eating habits. Invite them for dinner at your house. Discuss food. Join Meals-on-Wheels.

Find past newsletters:

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

PATIENT PAGES

- 1) [Advanced Care Planning](#)
- 2) [Testing for Coronary Microvascular Dysfunction](#)
- 3) [Paraesophageal Hernia Repair](#)



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Answer to question: e) \$2,500 (<https://time.com/5759972/health-care-administrative-costs/>).

Sites and Links

We need to do a better fight against doctor sex abuse: https://msmagazine.com/2018/07/26/can-fight-doctorsexabuse/?utm_source=email&utm_medium=social&utm_campaign=SocialWarfare

Oped on antibiotic resistant microbes in nursing homes (Kevin Kavanagh, MD):
<https://www.kentucky.com/opinion/op-ed/article239272058.html>

Medical testing's dirty little secret (Society to Improve Diagnosis): <https://www.improvediagnosis.org/dxiq-column/medical-testings-dirty-little-secret-and-how-you-can-protect-yourself/>

What we should learn about other countries' healthcare systems:
<https://www.vox.com/2020/1/13/21055327/everybody-covered>

Medicaid expansion improved health in Southern States: <https://thehill.com/policy/healthcare/477133-study-medicaid-expansion-improved-health-in-southern-states>

U.S. spends \$2,500 per person in healthcare administrative costs each year, Canada spends \$550 (Time):
<https://time.com/5759972/health-care-administrative-costs/>

9-months pregnant woman given overdose of fentanyl in hospital and died:
https://www.kget.com/news/local-news/pregnant-woman-dies-after-reportedly-given-fentanyl/?fbclid=IwAR1lvf6-o7P9EPH_vdZLdGgm-3jCsZ9cplijNulUikLFCP3qlvX7Co3HkDc

Healthcare quality programs placed on hold due to funding lapse from administration:
<https://www.mcknights.com/news/quality-improvement-program-at-risk-due-to-funding-lapse/>

US hospitals are not ready for the Coronavirus (WSJ): <https://www.wsj.com/articles/u-s-hospitals-arent-ready-for-the-coronavirus-11579975968>

Is the way Maryland handles healthcare a model for the rest of the U.S.? <https://www.vox.com/policy-and-politics/2020/1/22/21055118/maryland-health-care-global-hospital-budget>

Near Universal insurance coverage under Obama Care:
<https://www.politico.com/news/agenda/2020/01/27/obamacares-secret-success-103589>

How kids lose Medicaid coverage in Texas: <https://www.texasobserver.org/in-texas-thousands-of-kids-lose-medicaid-coverage-each-month/>

Nutritional support of certain types of hospitalized patients saves lots of money (ASPEN):
<https://onlinelibrary.wiley.com/doi/10.1002/jpen.1768>

Study of healthcare waste in Washington State finds 600,000 were victims of unnecessary treatment:
https://www.propublica.org/article/unnecessary-medical-care-is-more-common-than-you-think?fbclid=IwAR305ivbc-7K56njYS_miTWdT6iSefCPyL72bzSk-Qn8_VOyYIbT_pOWiQ

Does socialized medical care provide better quality care than private care – YES in one case:
<https://www.kevinmd.com/blog/2020/01/does-socialized-medical-care-provide-higher-quality-than-private-care.html>