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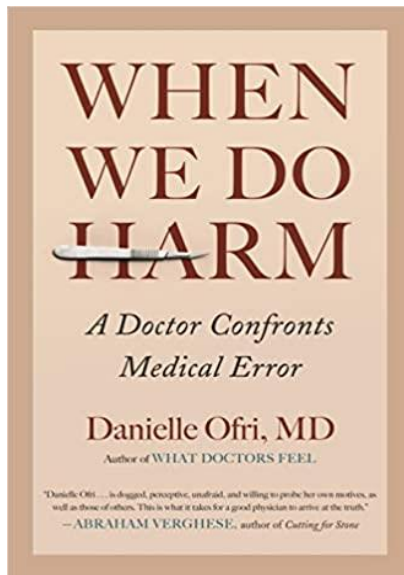
*Question: Where does the U.S. rank among countries for reported COVID-19 deaths?
 A) first B) second C) third D) fourth E) fifth F) sixth*

Book Review: When We Do Harm – A Doctor Confronts Medical Error

By Danielle Ofri, MD

I struggled some with this book. On the plus side, Dr. Ofri wrote several deep-running stories about medical error and the consequences of these for people involved in making the mistake and those who directly suffer because of it. She does this with grace and a thorough retelling of patient stories. Her focus seems to be on diagnostic errors, explaining potential ways these might be mitigated. She is not fan of the plethora of alerts from electronic medical records, many of them meaningless. These could be much improved she opines. She addresses the awful gauntlet of pursuing a malpractice case after a patient is harmed, leaning toward a no-fault system such as the one used in Denmark.

One fundamentally important misunderstanding is Dr. Ofri's thought that 'standard of care' and 'best medical care' are identical. This appeared on pages 136-7 where she wrote about the second criterion for proving malpractice – did the doctor follow the *standards* of medical care? She goes on to write that plaintiff's lawyer must prove that 'the doctor did not render the *best* medical care.' In fact, the so called 'standard of care' is a quite fuzzy concept that amounts to nothing more than what some marginally informed doctor claims it is. It is unhinged from 'best medical care.'



Her last chapter is about 'Getting It Right.' She admits that some caregivers are not as good as they should be. Hospital culture and human factors play an important part in how well individuals perform while working in a specific system. She calls for more involvement of patients, especially in ensuring the accuracy of medical records.

On the human side, she notes that many doctors carry their personal cemetery, which includes memories of those times when they could have given better treatment to a patient. Her honesty and open heart about medicine is remarkable.

On the downside, Dr. Ofri fails to understand the variety of ways patients receive poor quality care. She attacks the study by Marty Makary, MD, which led to a declaration that medical errors are the third leading cause of death. There are certainly problems with that study and the mistaken idea that medical errors occur in a vacuum free of patient vulnerabilities. I was disappointed that she did not acknowledge my study published years before Makary's and based on essentially the same data. Another topic I wish she had addressed is the failure of state medical boards to discipline doctors to prevent harm to patients.

This book is a valuable addition to the string of books written by physicians about the shortcomings of American medical care. Dr. Ofri leads with heart and wisdom as she recounts the suffering elicited by medical errors upon patients and survivors. 4/5 Stars. About \$26.

Healthcare of High-and Low-Income Adults in the U.S. and the U.K.

It is no secret that the American healthcare system and the one in the U.K. are quite different. According to the Organization for Economic Cooperation and Development, the [cost per capita](#) of healthcare in 2018 in the U.S. was \$10,586 whereas the cost in the U.K. was \$4,070 per capita. The U.K. has a socialized system, whereas, the U.S. has a for-profit system for the most part.

A [team of investigators](#) asked how people aged 55-64 compared for 16 healthcare outcomes from 2008 to 2016 in the two countries. They examined those outcomes on the wealthiest 20% and the poorest 20% in each country. Of the 16 measures, 13 showed a higher difference in the U.S. when compared to the U.K. Of those, the gap between low-and-high income groups between countries varied from 3.6% (stroke) to 9.9% (functional limitations). The authors state that the outcome gap between high-income groups and low-income groups appears larger in the U.S.

In these days of the pandemic, the disparity in healthcare between rich and poor Americans has been magnified. **It is time we all support legislation that gives every American consistently safe and affordable healthcare. Presently, we Americans are doing something wrong.**

Regional Variation in Hospitalizations of Medicare Patients

One approach to understanding the extent of overuse of invasive procedures is to ask how much variation there may between hospital referral regions (HRRs) in the end-of-life (EOL) care. A team of investigators asked [how much variation](#) there was in HRRs regarding three types of EOL care: in hospital, in the intensive care unit of a hospital, and hospice. They examined fee-for-service records of more than 7 million Medicare beneficiaries who died between 2010 and 2016 at a median age of 81 years.

For simplicity, let us look at the data at its extreme values. I will place the percentage-of-hospitalizations-in-2010/percentage-of-hospitalizations-in-2016. Then I will do the same for hospice care. For hospitalizations in the Manhattan, NY HRR the ratio was 44/34 and for Amarillo, TX

the ratio was 13/12. These are the highest and lowest percentages, respectively. These show an improvement (decrease) in hospitalizations in the 6 years of the study in the Manhattan HRR. The ratio for Amarillo was low in 2010 and continued to be low through 2016. The most important observation is that even in 2016 there was a nearly 3-fold difference (34 vs.12) in the rate of hospitalizations at the EOL when comparing hospitalization rates at the extremes.

Regarding hospice care, the 2010/2016 ratios for the Manhattan HRR were 23/34 and for the Amarillo HRR it was 65/66. More hospice care is showed up in Manhattan by 2016, whereas it is consistently high in Amarillo. I found it interesting that a Texas HRR had among the highest hospitalization rates in the country. The 2010/2016 hospitalization percentages for the McAllen, Texas HRR were 35/25, and the 2010/2016 hospice percentages were 27/48. The Texas State Health Services Department should ask why the rate of EOL hospitalization percentage is double in McAllen compared to Amarillo (25 vs. 12).

The authors call for more research into the disparities they uncovered, noting that their study has important limitations. I opine that the study provides convincing evidence of overuse of hospitalizations at the EOL. The studies I have seen suggest that patients approaching their EOL would prefer to die at home rather than in a hospital.

Illicit Marketing with Electronic Health Records (EHRs)

There seems to be no end to the nefarious ways certain medical industry companies try to market their products. My readers are aware of the opioid epidemic that has only come under limited control in the past year or so. Three experts wrote about the problem of marketing influence over clinical-decision support tools embedded in EHRs. One EHR vendor has agreed to pay a \$145 million fine for civil and criminal penalties related to taking kickbacks from a manufacturer of opioids. The manufacturer paid the EHR vendor to insert a clinical-decision aid into its EHR that led physicians to [prescribe more](#) of the company's long-acting opioids against standards of care.

The authors note that this type of activity is difficult to police but can obviously pose a danger to patients. Drug companies have already been fined for bribing physicians, misrepresenting addiction, downplaying poor safety, and promoting unnecessary use of unsafe drugs. One must ask if there is no system that cannot be exploited by greedy drug marketing.

Shared Decision-Making (SDM) Tool Applied to Patients with Atrial Fibrillation

Atrial fibrillation (AFib) is common and can lead to clots that cause a stroke. There are several choices to be made about how to treat patients to reduce the risk of stroke. A large [team of experts](#) tested the effects of using a SDM tool to facilitate communication between clinician and AFib patients. Roughly 460 patients each were randomized to the SDM group or the ordinary care group. The tool presents individualized risk estimates and address issues typically of importance to patients. Patient involvement in the SDM process was better in the group using the tool. About 86% of the patients agreed to start or to continue anticoagulant medication. Use of the tool required no more clinician time than the usual practice. The lesson for patients: Ask to see an SDM tool in anticipation of a discussion with your clinician about a critical aspect of your medical care.

Serious Ethical Violations in Medicine

Somehow, I came across an interesting article from 1 ½ years ago that revealed findings of ethical violations by U.S. physicians from 2008 to 2016. The investigation was published in *The American Journal of Bioethics*. The investigators focused on sexual abuse, criminal prescribing of opioids, and unnecessary surgeries. Interestingly, 95% of the violations were by male doctors. The vast majority were repeated offenses, involved non-academic settings, and were enabled by poor oversight. About half the cases involved a doctor with a personality disorder or substance abuse problem. The authors note that such ethical violations are difficult to detect. Among the authors' recommendations was one to empower patients to know how to detect the signs of unethical conduct in

their doctor. Patients should also know their rights. For example, if an examination of a sexual nature is necessary, then the patient has the right to a chaperone.

The citation for this study, which is behind a pay wall, is as follows:

James M. DuBois, Emily E. Anderson, John T. Chibnall, Jessica Mozersky & Heidi A. Walsh (2019) Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States From 2008–2016, *The American Journal of Bioethics*, 19:1, 16-34, DOI: 10.1080/15265161.2018.1544305

COVID-19 Collection

Health Watch USA Newsletter (great COVID-19 info):

<http://www.healthwatchusa.org/HWUSA-Publications/Newsletters/20200801-HWUSA-Newsletter.pdf>

Why America has struggled with response to COVID-19 (Bloomberg):

https://www.bloomberg.com/news/articles/2020-07-02/face-mask-safety-memes-on-covid-spark-disinformation-crisis?utm_campaign=news&utm_medium=bd&utm_source=url_link

What if the NTSB examined our response to the pandemic?

<https://www.theatlantic.com/politics/archive/2020/06/how-white-house-coronavirus-response-went-wrong/613591/>

Patient and public involvement must be part of pandemic response:

<https://www.bmj.com/content/370/bmj.m2575.full>

GAO report explaining heard immunity:

<https://www.gao.gov/products/GAO-20-646SP>

Silver bullet to treat COVID Midland doctor says (youtube):

<https://www.youtube.com/watch?v=eDSDdwN2Xcg&feature=youtu.be>

Overturning the ACA will make the COVID pandemic much worse (USA Today):

<https://www.usatoday.com/story/opinion/2020/07/08/trump-goal-throw-millions-off-health-insurance-in-pandemic->

[column/5386611002/?utm_source=alert&utm_medium=email&utm_campaign=OpEd](https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities)

Medicare coverage for mental health services during the pandemic:

<https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities>

The dilemma of how to reopen schools this fall:

https://jamanetwork.com/journals/jama/fullarticle/2768352?guestAccessKey=68111752-073d-41e5-950e-7b1406dc0ebe&utm_source=silverchair&utm_campaign=jama_network&utm_content=ped_weekly_highlights&cmp=1&utm_medium=email

ANTIBODY BAD NEWS

Antibody Levels Falling in 3 Months or Less:

- <https://www.nature.com/articles/s41586-020-2456-9>
- <https://www.nature.com/articles/s41591-020-0965-6>

Sweden's Population Does Not Have High Antibodies:

- <https://www.foreignaffairs.com/articles/sweden/2020-05-20/swedens-coronavirus-strategy-should-not-be-worlds>
- <https://www.uu.se/en/news-media/news/article/?id=14756&typ=artikel>

California's Population Does Not Have High Antibodies:

- <https://www.latimes.com/california/story/2020-06-05/how-many-people-in-l-a-actually-have-coronavirus-why-health-officials-still-dont-know-for-sure>

Spain's Population Does Not Have High Antibodies

- [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31483-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31483-5/fulltext)

Shelter-in-Place Orders reduced COVID-19 mortality (Health Affairs):

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00719>

Answer to question: A -first as of August 2. <https://www.worldometers.info/coronavirus/countries-where-coronavirus-has-spread/>

Doubts about herd immunity (Vox):

<https://www.vox.com/2020/7/12/21321653/getting-covid-19-twice-reinfection-antibody-herd-immunity>

Media reporting and science (JAMA):

https://jamanetwork.com/journals/jama/fullarticle/2768397?utm_source=silverchair&utm_campaign=jama_network&utm_content=covid_weekly_highlights&utm_medium=email

Universal masking to prevent virus spread (JAMA):

https://jamanetwork.com/journals/jama/fullarticle/2768532?guestAccessKey=163d0790-41cf-483f-86f7-6b2f99659278&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=071420

Crisis and opportunity of the Covid-19 Pandemic (Commonwealth Fund):

<https://www.commonwealthfund.org/publications/journal-article/2020/jul/crises-and-opportunities-covid-19-pandemic>

Dr. Fauci optimistic for vaccine by the end of 2020:

<https://thehill.com/policy/healthcare/509962-fauci-cautiously-optimistic-coronavirus-vaccine-will-be-ready-before-end-of>

Balanced article on COVID-19 vaccine:

<https://www.theatlantic.com/health/archive/2020/07/covid-19-vaccine-reality-check/614566/>

Find past newsletters:

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



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