PSA

Patient Safety America Newsletter

April 2022 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: What portion of diagnoses of Medicare-age patients are a misdiagnosis?
A) 5% B) 10% C) 15% D) 20% E) 25%

Balancing Overuse with Under Use of Procedures

Overuse and underuse of medical procedures are common phenomena in US medicine. A couple of experts wrote about the economic forces and the insights from machine learning that offer a means of reducing overuse, which saves money, and of reducing underuse, which saves patients health.[1] They describe an example where emergency physicians may attempt to diagnose acute coronary syndrome in patients with a variety of symptoms. An algorithm was developed to assist emergency physicians to identify which patients are unlikely to test positive and which may not benefit from the testing. This matters because a patient's life may be at stake for a delayed or missed diagnosis.

When applied in a clinical setting, testing of low-risk patients yielded a cost of up to $1 million per life year saved, whereas, restricting the testing to high-risk patients only, gave a cost of $46,000 per life year saved. They note that their findings suggest a large-scale inefficiency in testing for acute coronary syndrome. The authors observe that even within a given emergency room, different shifts of clinicians have a different balance of overuse and underuse. They tend to have a simpler and incomplete mental model of when to test, or not. The machine learning model is more complete.

In the wake of the finding that there is widespread *underuse* of care that is of high value and well reimbursed, the authors opine that there is no clear explanation. This may be an opportunity for the patient or her advocate to enter the conversation about next steps in care. What are the risks and benefits of the present choices? Note that the wise patient will ask for quantitative probability of each benefit and hazard. Neither benefit nor risk mean anything without the communicating the probability of each benefit and each harm happening.

Screening for Eating Disorders

The United States Preventive Services Task Force just issued guidelines for screening asymptomatic patients for eating disorders.[2] The group's conclusion was that there was insufficient evidence to make a recommendation for screening, at least in asymptomatic patients. That said, there are tools that primary care doctors may use to screen for eating disorders. These tools focus on disorders involving undereating. This is more common in women. In the other direction, it may be obvious that a person with a high BMI has an eating disorder that may involve factors such as binge eating or eating in secret. Eating disorders may impact both mental and physical health, so ignoring them is unwise. The experts, as they are prone to do, call for more research. The role of the patient or her advocate is to open a discussion about body weight with the primary care physician. That physician may make a referral to help manage weight.

First Generic Medication for Dry Eye Treatment

In a section called 'News from the Food and Drug Administration' in the *JAMA*, the story is told of FDA's approval of a generic equivalent for the highly advertised drug Restasis (cyclosporine emulsion).[3] The side effects reported for this drug include the following: burning of the eyes, dilated blood vessels, too much watering, and blurred

[1] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2789384

[2] https://pubmed.ncbi.nlm.nih.gov/35289838/

[3] https://jamanetwork.com/journals/jama/fullarticle/2789986

vision. The mechanism of action involves changes in the patient's immune system, thereby reducing eye inflammation, which causes the painful, dry sensation. The FDA played a key role in fostering the development of the generic drug, which is produced by Mylan Pharmaceuticals. If you are among the millions who suffer from dry eye, then your treatment should become much less expensive. The Aduhelm approval debacle notwithstanding, the FDA tries to be on the side of the patient – sometimes.

Diagnostic Excellence in the Elderly

Like it or not, most of us will one day be labelled 'elderly,' a label that is reserved for those who are 65 years old and older. A couple of experts wrote their viewpoint on the challenges faced by clinicians when diagnosing elderly folks.[4] We the elderly comprise about 20% of the US population and we are misdiagnosed about 10% of the time according to a meta study published in 2016. The experts opined that the challenges in diagnosing the elderly involve 5 factors as follows: increased medical complexity, over-and-under diagnosis, subtle symptoms, ageist thinking of the clinician, and failure to fully engage patient and family. The writers note that some elderly patients may not want treatments thought to be useful by the clinician. Communication skills are important in both directions as the preferences of the patient are expressed and respected.

I might have added to the mix of challenges in the elderly that many drugs are not tested on the elderly before FDA approval. Basically, these drugs are off label for the elderly, and it is more likely that they may have adverse reactions to a new drug or suffer from polypharmacy, which involves taking 5 or more drugs. It may well be that the 'diagnosis' is a side effect of the drug. The patient has a key role in helping to get the diagnosis right. Symptoms should be honestly reported.

Maternal Deaths an Embarrassment for the US

Maternal death is the death of a woman during pregnancy and 42 days postpartum from causes related to pregnancy and delivery. In JAMA Health Forum, an expert wrote about the unfortunate situation with maternal mortality in the US.[5] In 2018 our maternal mortality was 658 and in 2020 it was 861. The latter amounts to 23.8 deaths per 100,000 pregnancies. That rate is double what it is in 10 other developed countries. The racial disparities in the US are astonishing. Black women are 2-3 times more likely to die a maternal death than white women. Pregnant women over 40 years old are at 8 times higher risk of mortality than women 25 years old and younger. Funding to help solve this problem is stalled in the US Senate. The Centers for Medicare and Medicaid Services has an initiative to designate worthy hospitals as 'birthing friendly.' How can a country that spends far more on healthcare per capita than any other developed country have such shameful maternal mortality rates? It is complicated.

Physicians Spreading Bad Information about COVID-19

One of the key factors emerging during the pandemic was that some physicians are willing to push bogus information to the public. The question then becomes what should be done about this to protect the public? The primary responsibility falls to state medical boards who are notoriously lax in disciplining physicians for any reason. A News & Analysis article in the JAMA surveyed the actions, or inaction, of state medical boards to discipline doctors who spread harmful misinformation.[6] The nature of bogus information includes anti-vaccination opinions that are unscientific, favorable information on treatments that are known *not* to work, and speaking against use of masks.

The Federation of State Medical Boards has warned that misinformation dissemination could lead to state board discipline. This seems to have had little effect on the situation. Although 2/3rds of state medical boards have received complaints about misinformation, only 21% have disciplined a physician for unscientific information. The Hopkins School of public health has estimated that 2-12 million Americans are unvaccinated because of bad information from medical sources. One Houston

[4] https://jamanetwork.com/journals/jama/article-abstract/2789407

[5] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2790036

[6] https://jamanetwork.com/journals/jama/fullarticle/2789369

physician was fired from a major hospital system because she disseminated dangerously false information.

The warning for patients is to independently verify any information critical to how you respond to this pandemic. In the US, this is particularly important regarding vaccine misinformation as an article by a lawyer published in JAMA Health Forum illustrates.[7] The writer notes that the Supreme Court must balance our core privileges to free speech with the need to stop harmful misinformation. During the pandemic, the government tried to overcome misinformation about COVID-19 vaccines by disseminating truth in various ways. It did not attempt to directly punish those who disseminated false information. The problem these days is that such misinformation may be readily spread via social media. The opinion of the author is that the Supreme Court will restrict free speech in some instances where little harm is caused (e.g., television news pundits) but allow it when genuine harm is caused, such as in the case of vaccine misinformation. The writer points out that this attitude toward free speech leaves us uniquely vulnerable to public health threats compared to other developed nations.

Medical Debt is Burden for Millions of Americans

An article in the JAMA Health Forum describes findings of a Kaiser Family Foundation report on the problem of medical debt for Americans.[8] Nearly 10% of American adults have medical debt of $250 or more. This totals to about $195 billion for all Americans. The debt falls most heavily on black Americans, women, people living with serious health problems, and people living in states that did not expand Medicaid. Causes include high deductibles, denied claims by insurance companies, and billing for out-of-network treatment. Medicare beneficiaries have a lower debt burden than other groups. As you may know, incurring medical debt is a uniquely American problem among developed countries.

Remote Monitoring During the Pandemic and Patient Safety

It is no secret that patient safety took a nosedive during the worst parts of the pandemic; however, three experts give their view that during the pandemic many hospitals learned to do remote monitoring of inpatients and outpatients to manage the extra burden placed on resources when caring for them.[9] For example, a COVID patient with mild symptoms could be sent home from the ER with pulse oximetry monitoring of their oxygen levels to determine if they need to return for additional care. The 'system' learned how to prioritize the patients that need admission and those that can do well with home monitoring. In addition, monitoring priorities for inpatients were established. The Centers for Medicare and Medicaid Services also enhanced payment for home monitoring by reducing the number of days from 18 to 2 for payment.

The experts characterize some of the barriers to remote monitoring. These include improved technology infrastructure, protocols for inpatient monitoring, establishing teams to implement monitoring, better ways to pay for this service, and combining technology to monitor key parameters. The experts claim that remote monitoring could include blood pressure, body temperature, electrocardiogram, oxygen levels, and heart rate. If you are an inpatient, it might be a good idea to ask if you can be part of remote monitoring. If you do not want to be hospitalized after showing up at the ER, you might ask if remote monitoring at home would ensure your safety. This discussion should be part of shared decision-making with your clinician.

Shared Decision Making Comes of Age

The US Preventive Services Task Force (USPSTF) wrote to clinicians about the role of shared decision-making (SDM) between patient and clinician in JAMA.[10] While the article's target is education of clinicians, it would be wise for patients to become better informed about the level of certainty set by the USPSTF pertaining to screening for disease and the role of SDM. Recommendations A and B have a high to moderate certainty, respectively, of being of value for screening of

[7] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2790169

[8] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2790558

[9] https://pubmed.ncbi.nlm.nih.gov/35212725/

[10] https://pubmed.ncbi.nlm.nih.gov/35315879/

populations. At the individual level, the patient's preferences may be such that they forgo such screening. Recommendations at the C level, which means a potential small benefit at the population level, SDM seems essential as the patient's preferences guide the choice. Recommendations with a D (chances of harm) or I (insufficient data to make a judgement) designation should be discussed only if the patient asks the clinician about these. Screening is not recommended in either case.

One point to emphasize is that use of patient decision aids prior to SDM may be important. At present, well-vetted decision aids are underutilized, so the patient should ask about their availability. The USPSTF acknowledges that the patient has a right to SDM when it comes to screening for disease. Moreover, the patient's risk factors must be considered while deciding about screening. It is complicated, but not impossible to optimize your screening choices.

Interesting Links

New law will change the way companies deal with healthcare systems (Forbes): https://www.forbes.com/sites/leahbinder/2022/02/28/this-federal-law-will-completely-overhaul-company-health-benefits-nobody-is-ready/?sh=5392cd9016b6

WHO 2022 patient safety theme 'Medication Safety': https://www.who.int/news-room/events/detail/2022/09/17/default-calendar/world-patient-safety-day-2022/

Complaints mount about patients not being able to get their medical records (STAT): https://www.statnews.com/2022/03/10/health-information-blocking-complaints/

Podcasts of Dr. Death of Texas:

"Inside Dr. Death-Part 1" - The Life Medical, 2022 - The Life Medical on Apple Podcasts (1hr., 6 min)

"Inside Dr. Death-Part 2" - The Life Medical, 2022 –

https://podcasts.apple.com/us/podcast/the-life-medical/id1551508555?i=1000554200542 (1 hr., 21 min)

US in denial about new COVID variant: https://www.theguardian.com/commentisfree/2022/mar/16/once-again-america-is-in-denial-about-signs-of-a-fresh-covid-wave

Healthgrades link to finding top hospitals near you (try it!): https://www.healthgrades.com/quality/patient-safety-excellence-award?cid=63emPSv2

US compares unfavorably with other high-income countries on primary care access: https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares

American Association of Family Physicians on Choosing Wisely in 300 medical circumstances: https://www.aafp.org/afp/recommendations/search.htm?cmpid=em_AFP_Retn4

Becker's top 10 patient safety concerns for 2022: https://www.beckershospitalreview.com/patient-flow/10-top-patient-safety-concerns-for-2022.html

Nurse made a medication error that was lethal. She is up for criminal prosecution in Tennessee: https://www.npr.org/sections/health-shots/2022/03/22/1087903348/as-a-nurse-faces-prison-for-a-deadly-error-her-colleagues-worry-could-i-be-next

Criminalization of medical errors is not the answer: https://www.beckershospitalreview.com/patient-safety-outcomes/we-can-t-punish-our-way-to-safer-medical-practices-2-experts-on-criminalization-of-medical-errors.html?utm_medium=email&utm_content=newsletter

Health Watch USA newsletter (focus on COVID): http://www.healthwatchusa.org/HWUSA-Publications/Newsletters/20220401-HWUSA-Newsletter.pdf

NATIONAL QUALITY FORUM MEMBER

Find past newsletters:
http://patientsafetyamerica.com/e-newsletter/

Answer to question: (B) about 10%, reference #4