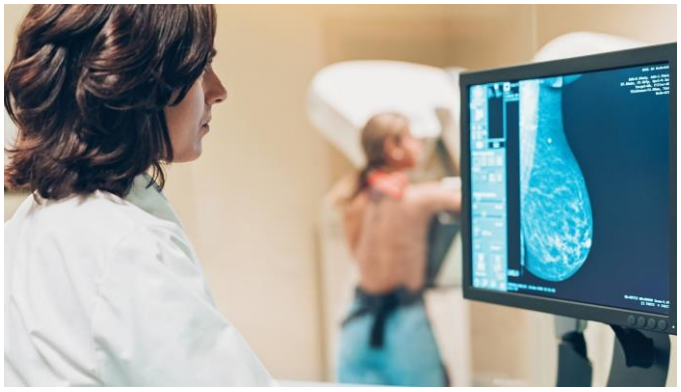
Patient Safety America Newsletter

September 2024 http://PatientSafetyAmerica.com *John T. James, Ph.D.*

Question: Roughly how many Americans report food insecurity? A) 1/10 B) 1/25 C) 1/50 D) 1/100

Breast Cancer Screening

In a medical news brief in *JAMA* the writer summarizes new information on shared decision-making and screening for breast cancer in women at ordinary risk for getting that cancer.[1] In April of this year, the experts recommended screening every 2 years with mammography for women 40 to 74 years old. A study recently published in *Annals of Internal Medicine*, showed that women in the 39-49 age group may wish to forgo screening until they are 50



years old *after* they learned the risks and benefits of screening. The percentage wishing to delay screening went from 9% to 18% after they were educated on the risks and benefits. In my opinion, the lesson for women at average risk of breast cancer and of any age should learn the risks and benefits of mammography. If you wish to have a credible estimate of your risk of breast cancer up to the age of 90 years, the National Cancer Institute has such a tool.[2] It is meant for physicians, but with perseverance, others should be able to use it.

Drug Attributable Harm

Three experts call for finding a way to estimate how much harm comes to patients from the drugs they are using.[3] The authors divide the causes of drug deaths into three categories – street-drug attributable, alcohol attributable, and tobacco attributable. The estimated annual premature deaths from use of these drugs are as follows: 105,000, 137,000, and 550,000, respectively. These are from the Institute of Health Metrics and Evaluation as of 2019. The authors call for more attention to go beyond premature deaths to the number of Quality Adjusted Life Years (QALYs) lost due to drugs used. Most of us have seen the TV commercials where a person who is clearly disabled or disfigured begs the audience to give up smoking or other tobacco use.

In my opinion, people who misuse alcohol or tobacco and become hospitalized are not being given the post-discharge support they need to cease their dangerous behaviors. An example of the challenges of post-discharge care have been chronicled.[4] I would also ask the 'system' to begin keeping track of premature deaths caused by medications, including polypharmacy.[5] Polypharmacy has nearly doubled in the past 20 years.

Abortion Bans Cause Harm

Those with some degree of tunnel vision may be unaware (as I was) about the harm that can arise from abortion bans. Three experts trace the pathways that have led to abortion bans in Texas and

[1] https://jamanetwork.com/journals/jama/article-abstract/2821998

[2] https://bcrisktool.cancer.gov/

[3] https://jamanetwork.com/journals/jama/article-abstract/2821245

[4] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2793720

[5] https://www.nature.com/articles/s41598-020-75888-8

the harm generated.[6] One level of harm focuses on physicians trying to manage patients who would ordinarily have access to abortion as evidence-based care, but they cannot have this procedure due to an abortion ban. The mother must wait to become 'critically ill' before an abortion is performed. This has caused some obstetricians to leave Texas. Expectant mothers facing complications must deal with risks associated with delayed treatment until they are in a 'critical' condition, such as uterine rupture. The third harm comes to babies that would normally be aborted but are born with serious genetic abnormalities. These infants suffer and are more likely to die if their genetic abnormalities are severe. The authors note that the harm caused by abortion bans falls disproportionately on disadvantaged communities. They opine that this 'selling point' is one way to reduce the harm from abortions. They further opine that expectant mothers should have the support to carry a pregnancy to full term or have an abortion if the baby has serious genetic malformations.

In my opinion, the abortion debate is one of the silliest things around. Ethics would dictate that a woman who finds herself pregnant should have 12 to 18 weeks to decide if she wishes to have a baby. Most miscarriages happen during the first trimester (13 weeks). Prior to that time, the fetus is not sentient. Lots of genetic screening can be accomplished during the first trimester. Other tests may have to wait until 16-18 weeks of gestation. After that period, there is no excuse for needing an abortion except in cases of serious harm to the mother or baby. In 2022, 15 weeks of gestation was proposed as the abortion limit by Senator Lindsay Graham, of whom I am seldom a fan.[7] Those with ironclad tunnel vision quashed it. Neither of the extremes – no abortions or abortions until the baby would survive outside the womb (about 22 weeks of gestation) make any sense.

Severe Liver Injury after Drug Initiation

A huge team of investigators sought to identify drugs that in real-world usage pose a risk of acute, severe liver injury.[8] They identified Veterans Affairs patients without any known liver injury who had drugs administered some time from 2000 and 2021. They identified 7,900,000 patients and more than 190 drugs for study. They used several indices for acute live injury (ALI) that required hospitalization. The average age was 64 years old and 92% were males. More than half of the patients had polypharmacy. The rates of drug-induced injury were calculated as number per 10,000 person years. The rates of ALI ranged from 0 to 86 (stavudine). Seven drugs had 10 or more cases (stavudine, erlotinib, lenalidomide or thalidomide, chlorpromazine, metronidazole, prochlorperazine, and isoniazid). They noted that case report data on incidence *did not* match their real-world data.

I think the message here is to learn all you can about the side effects of your medications and be vigilant about assessing your wellbeing after starting a new drug, especially if you have polypharmacy. Know what side effects are predicted for your new drug and how it might interact with your current drugs.

Rise of Drug-Resistant Fungus

It appears that the incidence of COVID cases is on the rise, so I am reluctant to report investigations suggesting that there is a new strain of fungus that bears public health attention across the globe.[9] It seems to present as a nasty form of ringworm that is scaley and presents in bodily locations that ordinary ring worm does not appear. It is called *Trichophyton indotineae*. The case described in the U.S was brought here from Bangladesh.

For a decade doctors in India have been battling this fungus. Research has suggested that people become vulnerable to it when misusing topical corticosteroid, antifungal, and antibacterial combination creams. The steroid will reduce the

[6] https://jamanetwork.com/journals/jamapediatrics/article-abstract/2819789

[7] https://www.cnn.com/2022/09/13/politics/lindsey-graham-abortion-15-week-ban/index.htm

[8] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2820267

[9] https://pubmed.ncbi.nlm.nih.gov/39178006/

itchy infection after a few days use, but this does not stop the fungus from being present and potentially spreading to other people. The surveillance of such infections is less than robust, but medical scientists are increasing efforts to deal with this weakness. An expert group has created a tutorial on how to diagnose infection with *T indotineae*. One problem is that the fungus can mimic less concerning fungi and so gets overlooked. The Academy of Dermatology is spearheading the effort to ensure that cases are properly diagnosed and compiled into a registry.

Not to alarm anyone, but if you have a case of 'ring worm' that is widespread, itchy and scaley, you may want to ask your dermatologist about this fungus if a course of terbinafine does not clear it up. If someone you know may have this fungus, you must avoid contact with them. Immune compromised folks are especially vulnerable to this sort of fungal infection.

Medicare Dis-Advantage Plans

Three MDs wrote their viewpoint in *JAMA Internal Medicine* that Medicare Advantage (MA) Plans lead to less care at higher cost.[10] The Medicare Advisory Commission that reports to Congress has estimated that MA plans resulted in $82 billion extra cost to taxpayers in a single year. The strategies used by MA plans include upcoding the number and severity of diagnoses. A second strategy, which has somewhat diminished in recent years, is carefully selecting patients whose cost to treat is not likely to exceed payments from Medicare for that patient. The authors liken the situation to a cat-and-mouse game. The government tries to make MA insurers play fair and the MA insurers find clever ways to game the rules. One factor that I never thought of was that many MA plans offer fitness benefits to attract healthier beneficiaries. In summary the authors note the following: 'MA's overhead is mostly the price of their profits. A minority goes for profits; most funds the bureaucracy needed to up-code, cherry pick, and erect barriers to high-value care.'

The authors call for abolishing MA and returning all beneficiaries to the conventional plan of paying for services rendered. They note that under traditional plans, there must be a renewed check on Medicare paying for services not needed by the patient. I personally think that some of the payments Medicare gives providers are far too low to cover the cost of providing that service. I also think that Medicare should make it easier to engage its beneficiaries in fraud detection and in how to do shared decision-making to reduce unnecessary procedures.

Enhancement of Food is Medicine

An article in *JAMA Health Forum* caught my eye because it featured in its title the concept of 'behavioral economics' as it might apply to convincing Americans to improve their diets.[11] The article begins with this declaration: 'In the US, approximately 9 in10 children and adults consume too little fruit and vegetables and too much sodium, and 5 in10 adults have at least 1 sugary drink per day. More than 1 in 10 children and adults report food insecurity, defined as insufficient access to food needed for a healthy, active life.' The American Heart Association has created an initiative called Food is Medicine as a research effort. The idea is to eventually convince healthcare insurers to cover the cost of programs that serve at-risk populations. The issue becomes how behavioral changes can be elicited in the target populations.

Behavioral economics involves a combination of insights from economics and psychology to foster rational choices about what people chose to eat, especially if the nutritious food is expensive. The authors note that people's 'cognitive resources' are overloaded. By this, I think they mean online messaging. They propose a four-step plan to make Food is Medicine a reality.

The first step is to motivate clinicians to make referrals of appropriate patients to resources that will help them with access to healthy food.

[10] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2819817

[11] https://pubmed.ncbi.nlm.nih.gov/38995633/

These referrals could be automated to expedite this happening. The second step is for there to be incentives at the point of choice to make a healthy decision. Small cash incentives may help people overcome the system's tendency to feature poor choices at key points. Who among us has not waited to check out of a grocery store as we see all sorts of bad food choices beckoning us to buy them. This brings us to the third step. Somehow control the presentation of food options. An example that comes to my mind would be for the produce sections of grocery stores to feature a large sign reminding patrons that healthy food is medicine. The fourth step is to build a database of what is working and what is not. The article was written by two PhD's, so research is close to their minds.

If you are like me, you know the healthy choices that you should make, but you are often lured into making poor choices by circumstances. Just last night, I ate some exceptionally tasty pizza. It was called 'the works.' I am certain that the sodium in it shot my blood pressure up.

Sites and Links

Video on diagnostic errors from Patients for Patient Safety: https://www.pfps.us/diagnostic-safety

Atlanta hospital bills patient for its mistakes: https://www.nbcnews.com/news/us-news/couple-sues-atlanta-hospital-allegedly-losing-part-patients-skull-brai-rcna167063

CEO's of non-profit hospitals make an average of $1 M/year. Does that help patients? https://www.npr.org/sections/shots-health-news/2024/08/19/nx-s1-5078495/nonprofit-hospitals-ceo-compensation-community-benefit-uninsured-mission-tax-exempt-management

Unexpected bills and denied coverage in the US (Commonwealth Fund): https://www.commonwealthfund.org/publications/issue-briefs/2024/

Young woman's body put in storage by hospital that told her family she had checked out: https://www.yahoo.com/news/hospital-told-family-daughter-had-003113865.html?

Mom's intuition saved her son's life from negligent doctors: https://people.com/mom-pediatric-sarcoma-trust-parents-intuition-children-health-concerns-exclusive-8686122

Hedge funds in healthcare: https://laist.com/brief/news/health/big-california-health-care-businesses-win-exemptions-from-proposed-hedge-fund-rules

Research fraud in healthcare can kill thousands prematurely: https://www.vox.com/future-perfect/368350/scientific-research-fraud-crime-jail-time

Another example of massive research fraud: https://retractionwatch.com/2024/08/13/former-maryland-dept-chair-with-19-million-in-grants-faked-data-in-13-papers-feds-say/

FDA not doing its job of monitoring medical devices: https://www.icij.org/investigations/implant-files/us-government-audit-identifies-challenges-in-fdas-monitoring-of-medical-devices-linked-to-patients/

NATIONAL QUALITY FORUM MEMBER

Answer to the Question: (A) 1/10. Food insecurity is insufficient access to food that results in a healthy lifestyle. From ref. #11.

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