PSA

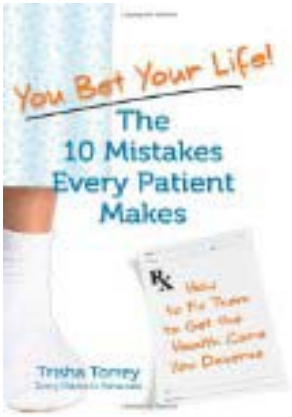
Patient Safety America Newsletter

March 2010 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: According to an article published last month in the Archives of Internal Medicine, how much does Medicare overpay each year for erroneous billing of physician consultation codes?
a) $5M b) $50M c) $500M d) $5B e) $50B f) $500B

BOOK REVIEW:
You Bet Your Life – The 10 Mistakes Every Patient Makes
By Trisha Torrey

Trisha Torrey is another person recruited to the patient safety movement by healthcare gone awry. In her case she was nearly subjected to heavy-handed treatment for a "strange" lymphoma. In the end, she had no cancer at all and was fortunate that she stepped up to become what she calls an "EmPatient" or Empowered Patient. In her book she has chronicled quite clearly why you must become an EmPatient if you want to improve your chances of survival in the face of a serious illness. Her style is straightforward and easy to follow as she examines the healthcare system from the perspective of patients, providers, and insurance people – and then systematically outlines what you must do to deal with a system that is not about your health or your care. American healthcare is about using illness to make money.



Ms. Torrey describes each of the ten mistakes patients typically make, and then suggests how to fix each mistake through patient empowerment. The list of mistakes should be relatively familiar to readers of this newsletter. Some of these are as follows: thinking your healthcare is focused on you, supposing that doctors put their patients' needs first, thinking you have been told about all your treatment options, not understanding the importance of accurate medical records, and paying too much attention to media information.

As a one-time researcher at the National Cancer Institute in the days when President Nixon had declared war on cancer, I found Ms. Torrey's chapter on "Believing All Medical Researchers are Searching for Cures" interesting. She describes a study showing how readily lung cancer can be treated if caught early. The findings were published in a highly respected journal, but drew criticism from other researchers and the public when it was apparent that the study was sponsored by a tobacco company. She concluded that the study was about saving money on lawsuits for the tobacco company, not about better care for patients. The war on cancer continues.

I might have added to her criticism of medical research. For example, we recently noted the discrediting of the seminal study linking vaccine use and autism (after her book was written).[1] Many people decided against vaccinations for their children based on this research, but apparently this study was wrong.

Researchers can also be criticized for too much basic research and not enough transitional research. Transitional research finds better ways to bring results of basic research to benefit patients. Historically, basic research has received most of the funding, and transitional research has been overlooked. Medical scientists, just like physicians, go where the money is.

Despite a somewhat grim portrait of greedy American healthcare, Ms. Torrey ends her book on a relatively positive note. She exhorts her EmPatients to become involved in the bigger picture of healthcare change. I might have concluded with a comment that there are many, many other healthcare systems in developed countries that work better than ours. There is no magic in attaining a high-performing healthcare system. Only the truculence of American opinion and the pandering of Congress to special interests in the healthcare industry have kept us trapped in a second rate system. EmPatients need to become a force for change, even while protecting their bodies from American healthcare. Ms. Torrey's book is an excellent, smoothly-flowing read for anyone who is naïve about healthcare and the fact that it is all about making money on your sickness. 4 ½ Stars.

The U.S. Healthcare System-No Olympic Medals Here

An informative perspective article written by two MDs was published this past month in the *New England Journal of Medicine*.[2] This article reinforces what I stated above about the U.S. healthcare system needing to learn some lessons from other systems. Basically, of the 191 countries subject to the comparisons, we ranked 37th overall in 2000. This ranking is despite the fact that we spend far more on healthcare per capita than any other major country in the world. Perhaps the U.S. healthcare industry should receive a gold medal for being the most expensive.

Not only does the U.S. rank poorly, we are falling further behind other countries in key measures of healthcare. The authors[2] graphically compare the probability of death for boys and men 15 to 60 years of age in Australia, Sweden, and the U.S. from 1970 to 2007. In 1970 our death rate was 0.23, Australia's was 0.21 and Sweden's was 0.14. By 2007 the Australians had made impressive gains, dropping their death rate to 0.07, and Sweden's rate had dropped to 0.08. Sadly, the death rate in the U.S. had dropped to only 0.14, about twice the other two countries' death rate.

The authors, declaring that the reform debate has not embraced prevention and wellness as well as it should, argue for more strategies that would reduce our high rates of smoking, obesity and hypertension. They note the huge disparities in death rates between regions in the U.S. and that periodic measurement of our progress, or lack thereof, is essential to gauging progress and finding what works. This all sounds fine, but I'm afraid if the pot of gold is not in prevention and wellness, then the American healthcare industry is not going to go there. They insist on *their* gold.

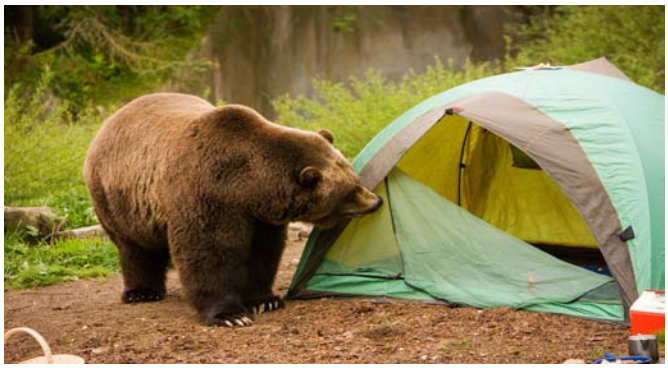
Five Gold Medals for this Idea

A physician ethicist [Howard Brody], writing a perspective article called "Medicine's ethical responsibility for health care reform – The top five list" presents a novel idea for his physician colleagues to implement as part of controlling healthcare costs.[3] He reminds his colleagues that they have each sworn to place the interests of patients ahead of their own. He notes the huge regional variations in healthcare costs [see page 1 of the April 2009 PSA Newsletter for comparison of Dallas and Atlanta] and that physicians cannot presume that they are "innocent bystanders" in the soaring costs of healthcare. Roughly 1/3 of healthcare costs could be saved without any loss of patient care. So, what can doctors do to become part of the solution?

Dr. Brody points out that practice more in accord with medical guidelines would certainly help. He makes a bold suggestion. Each medical specialty group should prepare a list of the five most "wasteful" tests or treatments in that specialty. These would be procedures that are commonly ordered, expensive, and not beneficial to major groups of patients to whom they have been applied. He recommended a couple of targets: arthroscopic surgery for knee osteoarthritis and CT scans for just about anything.

Once the wasteful procedures are identified, the specialty group should put pressure on members within that group to reduce over-use of the procedures. He views lists of five as a mere down payment from the physician community. More savings could be wrought with target lists of twenty wasteful tests per specialty. Dr. Brody notes that anti-reformists decry the government getting between patients and doctors. If physicians do not want that to happen, then they need to take the lead in waste elimination. He notes that by doctors taking the moral high ground some people might be astonished.

I'm afraid I would be one of those astonished if the suggestions from Dr. Brody came to pass. Knowing that there are many physicians who would never sell a test that a patient does not need, I also know that the physician community as a whole has failed on many important fronts over which it has control. For example, residents still work enormous hours even though it is well known that this compromises patient safety, the peer-review of physicians by physicians is badly broken, medical boards have a long tradition of irresponsible disciplining of dangerous doctors, many doctors are board certified for life without any requirement to demonstrate competency, and the continuing medical education system for physicians is so broken that a patient has no assurance that his doctor can provide safe, up-to-date care. It is only through appeals like that of Dr. Brody that change has a chance, but I think it is a very slim chance. Hold the gold medals for now. I'd love to be astonished.



Some Guidelines Earn Gold Medals

A year ago [March 2009 PSA Newsletter, page 3] I wrote about medical guidelines being a can of worms. I based my opinion on the incredible array of guidelines promulgated by innumerable medical organizations. There seemed to be no way to sort out this gooey mess. That just changed.

An admixture of MDs and PhDs looked at guidelines on cardiovascular risk assessment to determine which of the 27 suitable guidelines published from 2003 to 2009 were rigorously developed and which were not.[4] They used a tool called "AGREE" that looks at seven factors including quality of evidence gathering and extraction, attention to benefits and risks, procedures for external review of proposed guidelines, and updating processes. Their findings surprised me.

The judges' scores spanned the range from 10 to 98. The gold medal winners were as follows: National Institute for Health and Clinical Excellence (U.K.) with a score of 98 for guidelines on total cardiovascular risk, US Preventive Services Task Force for guidelines on dyslipidemia [disrupted levels of fats in the blood] and on dysglycemia [disturbed blood sugar regulation] with a score of 95 on each. Two scores were in the lower 80s, and the rest fell off quickly through the 70s into the teens. I was surprised to see the American Cancer Society, American Diabetes Association and American Heart Association's combined guidelines for the three areas scored only 14 points in each area for their guidelines published in 2004.

I do not know if there could be widespread adoption of the AGREE tool for assessment of guidelines; however, given the range from excellent to extremely poor in the rigor of development, it seems that the practicing physician and patients would value widespread application of such scores. Just as we patients want to know which hospitals are excellent and which doctors are excellent, we want to know which guidelines are excellent. Sadly, in all three cases we have to be careful of those that are far from excellent.

Medical Gas Guzzlers

In the world of automotive engineering manufacturers build gas guzzlers and fuel-efficient vehicles. Many Americans (too few Texans) pay careful attention to avoid buying vehicles that consume more gas than their fuel-efficient counterparts. It is time that those who purchase medical care do the same thing.

Last month five MDs wrote a perspective article entitled "Perioperative practice: Time to throttle back."[5] They begin by noting that on average the U.S. spends more on healthcare than other nations yet outcomes of that expensive healthcare produce inferior outcomes. This is something like having an old Corolla in such disrepair that it gets only10 mpg. We can, we must, do better.

One way these authors[5] propose to improve healthcare is by eliminating indiscriminate use of perioperative procedures [procedures performed before surgery] that have no demonstrated value. They cite three examples: coronary artery revascularization in patients with stable heart disease, routine stress tests, and beta-blocker therapy. Under some conditions, these strategies can be useful, but they must be applied to highly-selected patient populations before surgery. In fact, the over-use of beta-blockers can be dangerous or lethal to patients. They point out guidelines issued in 2007 by the American College of Cardiology/American Heart Association that give explicit circumstances under which perioperative cardiovascular procedures are evidence based. If physicians started following such procedures both costs and outcomes could be improved.

The authors systematically describe how populations of patients with heart problems can be specifically selected for appropriate perioperative care based on robust evidence.[5] They suggest the impediments to this include fear of litigation if something goes wrong, pressure from doctors who will do the surgery, and loss of income from refusing to do procedures that are worthless in specific circumstances. To quote the authors:[5] "It is thus imperative that any form of healthcare reform incentivize and link evidence-based care to payment…We must become more evidence-driven if we are to deliver better perioperative care in a cost-effective manner."

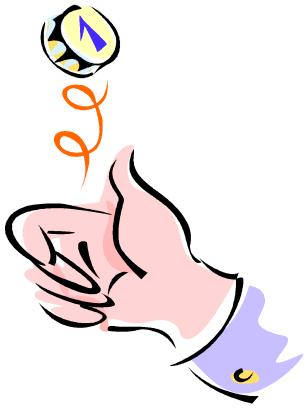
As an informed and cautious patient you have a role to play. When your cardiologist suggests a string of tests or therapy before surgery, ask him to write down for you the rationale for each procedure and which guideline he is following for your care. If he is deviating from guidelines, then you need to know why – in writing. Just because your insurance company or Medicare will pay for a procedure or drug does not mean it has value; in fact, it may be dangerous to your health.

Since money is the bottom line, I would recommend that in conditions where well-recognized guidelines are not followed and no rationale for deviation from those guidelines has been written by the

doctor, then no payment should be given, either to the doctor or to the hospital. It is time to abandon our gas-guzzling Corolla for something much better, or at least get a major tune-up.

Use of Decision-Making Tools in Medicine

Currently, Continuing Medical Education (CME) fails to ensure that doctors can consistently deliver high quality healthcare based on expert guidelines and scientific studies. Medical care can be incredibly complex, and a commentary in the *JAMA* suggests that decision tools must become the norm for clinicians.[6] The MD commentator believes that patients expect their doctor to know the right answer every time. I do not agree with that opinion; patients know doctors will make mistakes and a patient with any sense will ask challenging questions to improve their chances of receiving competent care. We do not expect perfection, but we certainly know that doctors could do much better than they do now – and more widespread use of decision tools is one possible strategy.



Rather than answer a series of discrete questions on some examination, the author believes that doctors should demonstrate that they can make the right decision when confronted with a medical situation. The goal is not that the physician carries around the right answers to deal with all situations, but that the physician knows how to find the right answers using evidence-based decision tools. This must become part of routine medical practice. I agree.

I have long argued for such an approach to CME. Physicians must be able to integrate the information in a patient's medical record and make evidence-based decisions on how to render optimal care. I also advocate the use of medical records in CME as a way to identify medical errors in actual medical care. Part of a physician's CME score should include his ability to identify mistakes in medical care based on the records, which could be from a challenging simulation or from an actual case of alleged malpractice. The physician would not know the source. This is the way to get the physician's expertise without the protective bias that most doctors maintain for each other.

It is always appropriate for an empowered patient to ask her doctor *how* he arrived at a particular decision in their care. How did you decide I needed those chemotherapeutic drugs? How did you decide that I needed a coronary artery stent? How did you decide that I needed that powerful combination of antibiotics? The answer I'd like to hear from my doctor is that he used a specific decision tool based on evidence from a well-regarded expert group.

The absence of a comprehensive and well-integrated system of continuing education in the health professions is an important contributing factor to knowledge and performance deficiencies at the individual and system level.

Institute of Medicine in ***Redesigning Continuing Education in the Health Professions.*** National Academy Press, 2010

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Answer to Question this month: c) approximately $534M is misspent by Medicare each year due to miscoding of medical consultation[7]