



Patient Safety America Newsletter

April 2011

<http://PatientSafetyAmerica.com>

John T. James, Ph.D.

Question: How much do potentially preventable hospital readmissions cost Medicare each year?

a) \$1.2 billion

b) \$12 billion

c) \$120 billion

d) \$1.2 trillion

Open Wide - Say Ugh!

When many of us were kids and had a sore throat, the doctor would hold out a big wooden tongue depressor and tell us to open up and say “Ah” as he mashed our tongue and peered into our painful throats. If we had known then what could befall us, we might have run away like one of the



pigs being pursued by the big, bad wolf. I recall having a tonsillectomy when I was about 5 years old and I remember two important outcomes: 1) my throat was incredibly sore for several days, and 2) my diet consisted of ice cream. The operation was not all bad. But there were dangers my parents never knew.

As early as 1938 it was known that areas with a high rate of tonsillectomies did *not* have improved child health over areas that practiced many fewer operations.¹ The excess operations were attributed to “prophylactic need.” Unfortunately, it was also known that many children who never needed a tonsillectomy died from anesthesia administered during the operation. Although the administration of anesthesia has certainly improved

in the intervening 73 years, it is only this year that the *first* U.S. guidelines for performing tonsillectomy have been released.² More than half a million children receive this operation annually and many may be inappropriate operations.

According to the new guidelines, the need for a tonsillectomy is determined by the frequency of a child’s sore throats. To count for this purpose, each sore throat must be accompanied by a fever of at least 38.3°C (101°F), swollen lymph nodes, pus or blood draining from the tonsils, *or* documented hemolytic streptococcus infection. The table below gives the frequency of these sore throats before a tonsillectomy should be considered.

Period of time over which sore throats occurred	Number of sore throats
One year	7
Two years	5 per year
Three years	3 per year

In my opinion the delay in declaring a guideline for this operation is unconscionable. We are talking about the health and suffering of young children and the difficult decision that worried parents must make. And the healthcare industry cannot be bothered to establish a standard for cases where a tonsillectomy makes sense. Perhaps this guideline will not matter much anyway since doctors follow guidelines as they please and the hapless insurance companies and Medicaid continue to pay on the basis of procedures performed – needed or not. For reference, the cost of a tonsillectomy with no insurance is about \$5,000. **At least as a parent or grandparent you now know that a guideline does exist for tonsillectomy and you can intelligently discuss this with the physician.**

Remarkable Texas Law and a Perfect Storm

Despite good intentions by the Texas legislature, the outcome of a law passed in 2009 (HB 1290) could be a slow disaster. The law insists that health insurance companies cover two cardiovascular screening tests to be performed every 5 years in men from 45 to 75 years old and in women from 55 to 75 years old if they have risk factors for cardiovascular disease. Taken at face value this might seem to be a good thing, but informed inspection suggests otherwise.

The mandated tests are coronary artery calcium (CAC) scan and carotid intima-media thickness (CIMT) test. The CAC scan uses radiation to image accumulated calcium deposits in the walls of arteries that feed blood to the heart. The CIMT test uses ultrasound to measure wall thickening in two layers in arteries that feed blood to the brain. Since there are no randomized trials showing that either test reduces the incidence of suffering or death, there are serious questions about performing them in a rather indiscriminant way.³ The cost estimate if all eligible Texans were to have the test in a given year would be \$480 million dollars.³

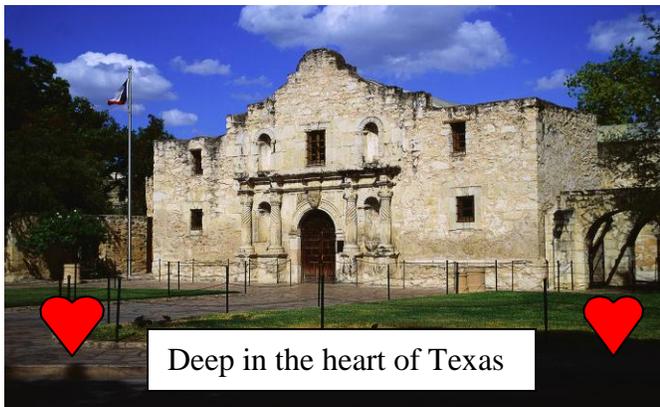
As if the potential costs for marginal tests were not enough, there are two important risks associated with such screening. Expert estimates suggest that roughly 200 new cancers caused by the screening would occur and about 200,000 findings of minimal clinical importance would be found that would require follow-up testing.³ The editor of the journal in which this review was published commented on the new law, noting that despite lack of demonstrated value of the testing and risks from cancer and follow up procedures, “Texas mandated that health insurance cover this procedure (CAC) for

millions of Texans...when Texas leads the nation in the percentage of residents without health insurance; it is remarkable that Texas has chosen this path.”



There is a perfect healthcare-access storm brewing for Texas. The Affordable Care Act, known by many Texans as Obama Care, mandates that in 2014 Medicaid expand its coverage to include those below 133% of the poverty level. In states with a disproportionate number of poor folks this will mean that many more people will be eligible for Medicaid coverage and need access to primary care physicians. Some states are already marginal when it comes to the number of primary care doctors. The authors of a perspective study in the *New England Journal*⁴ calculated an “access-challenge index” that divides anticipated Medicaid need by the lack of primary care doctors. They normalized this index to be 100 for the average state. The “intensity” of the coming storm for Texas was third worst in the country at 187.

Few of my readers are candidates for Medicaid; however, this coming storm could affect Texans using private insurance or Medicare. When Medicaid patients enter the “competition” for the limited number of primary care doctors in Texas, this important resource is likely to be strained. The problem could be confounded by doctors refusing to accept Medicare (or Medicaid) patients. The refusal to accept Medicare patients is already starting to happen in the area of Houston where I live. Experts have long called for increasing of the ratio of primary care doctors to specialists in the U.S. We have known the storm was coming, and we have done nothing to prepare for it. Specialists make too much more money than primary care physicians. No wonder we have a shortage of primary care doctors.



Curtailling Collateral Damage

Last month I reviewed a great book called “Collateral Damage” that described the harm suffered by a woman seeking care for her heart in a famous teaching hospital. In my reading this month



I came across a commentary article by two MDs describing why delivery of high quality healthcare is *not* a priority in teaching hospitals.⁵ It reinforced what I had read in the book by Dan Walter.

The commentary authors pointed out a 2007 study showing that 15 of the 20 top-performing hospitals for care of patients with acute coronary syndrome were community hospitals and not teaching hospitals. The authors suggest that misguided incentives for academic physicians in teaching hospitals cause the lack of attention to patient safety. Incentives focus on better pay, peer recognition, and promotion for winning research grant awards and publications. Incentives also might include the amount of clinical care delivered. In most academic settings physicians are not rewarded or given much recognition for improving patient safety within the teaching hospital. An academic physician is unlikely to be rewarded for “taking a leadership role in improving hospital-wide adherence to clinical practice guidelines.”

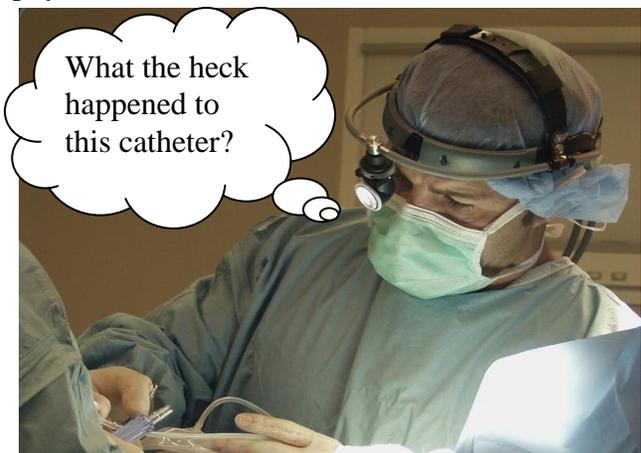
The authors survey the complexities of providing incentives necessary to draw the attention of academic physicians to improving patient care. These incentives could come from the hospital or third-party payers. Perhaps a “hospital hero” could be a physician who improved patient outcomes instead of one who received national recognition for discovering some gene. In the end the authors provide no specific incentives, declaring only that

“academic physicians do not currently, as a community, expend enough effort on improving health care quality. An examination of the incentives they face in setting their practices may offer an explanation as to why this is so.” In my opinion, until there is change, we all run the risk of becoming victims of “collateral damage.”

Improperly Used Tools of Medicine

Have you ever worked with someone just learning to do a job, and discovered that they were misusing a tool? When this sort of thing happens in medicine, the result can be tragic. An MD wrote a commentary describing how difficult it is to know how to use the various tools and information that physicians have at their disposal.⁶ She points to a study indicating that a physician would have to read 75 primary studies and 11 meta analyses (analysis of a collection of studies) *each day* to stay current – clearly an impossible task. The consequences are that iatrogenic deaths in hospitals are the third leading cause of death in the U.S.⁷, and despite concerted efforts at improvement, this death rate is not changing.⁸ The author attributes this to “high barriers in the physician community to adoption of evidence-based practice guidelines.”

The author attempts to survey research study modalities used by major federal agencies, and then tries to show how the results fail to help physicians individualize information for treatment of their patients. She does admit that the way forward is unclear; perhaps investigators should use “enrollment stratification” in major studies to discern for whom a treatment will work. There would still be a huge number of studies for physicians to review.



In my opinion she has overlooked two important factors. The first is that continuing

education of a physician falls far short of keeping him abreast of evidence-based guidelines. The second is that the healthcare community has no mechanism that I am aware of for rapidly sharing information about bad treatment outcomes. For example, restricted use or banning of a dangerous drug can come years, even decades, after it has been in common use. Effective education and rapid learning from mistakes do matter.

Duty to Warn

Few of us like to be told what we should do and few of us like to tell someone that they have a problem that needs attention. Thus, it is not surprising that physicians are often reluctant to tell



their patients that they are obese or overweight. One study cited in an *Archives* article reported that one-third to one half of overweight and obese patients were never told by their doctor that they were overweight or obese.⁹ When told that they were

overweight or obese by their doctors, patients were at least 5-fold more likely to have a desire to lose weight.

The commentary article suggests a 5-step process to engage the patient in effective weight loss. Obviously, this has to be done in a non-judgmental way. Unfortunately, patients that need to lose weight have a low probability of success without intensive intervention. I wrote about some strategies in my December 2010 issue. I know of several friends who have lost many pounds but ultimately they regain all the weight they lost and more.

Ultimately it is the duty of your physician to warn you of any behavior that is a threat to your health and life expectancy. In my opinion, a person who dies early because of obesity-related illness and was never told by a doctor to lose weight is a victim of malpractice. On the other hand, **if you are overweight, then ask your doctor to advise you on what to do to lose weight and keep it off.** If I were a physician and a portion of my overweight and obese patients lost a lot of weight I'd feel exceptionally good about the years added to their life. The gift of life is precious.

References

- 1) Glover, JA. The incidence of tonsillectomy in school children. *Proceedings of the Royal Society of Med.*, May 1938, ppg 1219-1236 as cited in Moulton, B. and King, JS. Aligning ethics with medical decision-making: The quest for informed patient choice. *J Law, Med Ethics*, Spring, 2010
- 2) Mitka, M. Guideline cites appropriateness criteria for performing tonsillectomy in children. *JAMA* 305:661-662, 2011
- 3) Khera, A. Texas atherosclerosis imaging bill. *Arch Intern Med* 171:281-283, 2011
- 4) Ku, L, K Jones, P Shin, et al. The states' next challenge – Securing primary care for expanded Medicaid populations. *New Engl J Med* 364:493-495, 2011
- 5) Dhalla, IA and AS Detsky. Aligning incentives for academic physicians to improve health care quality. *JAMA* 305:932-933, 2011
- 6) Zilberberg, MD. The clinical research enterprise – Time to change course? *JAMA* 305:604-605, 2011
- 7) Starfield, B. Is US health really the best in the world? *JAMA* 284:483-585, 2000
- 8) Landrigan, CP, GJ Parry, CB Bones, et al. Temporal trends in rates of patient harm resulting from medical care. *N Engl J Med* 363:2124-2134, 2010, correction 363:2573
- 9) Brown, RB. Telling patients they are overweight or obese. *Arch Intern Med* 171:321-322, 2011
- 10) Axon, RN and MV Williams. Hospital readmission as an accountability measure. *JAMA* 305:504-505, 2011

Answer to question this month (Medicare Patient Advisory Commission): b) \$12 billion¹⁰

Find past newsletters at:

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