PSA

Patient Safety America Newsletter

March 2014 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question:** From 1964 to 2012 life expectancy at 40 increased a total of 7.8 years in the US. How much of this was attributable to reductions in smoking? A) 1 year b) 2 years c) 3 years d) 4 years*

Worthless Treatment

The call for less use of "medicine" is beginning to take hold in the medical community, but will patients be willing to go along with the anticipated trend? Five MDs wrote an editorial in the JAMA Internal Medicine in which they survey the properties of medicine overuse: 1) benefits are negligible, 2) harms outweigh the benefits, and 3) an informed patient would choose no medical service.[1] They note that the economic cost of wasteful spending on medical care in the US has been estimated at about $750 billion per year. That's about $2,400 for every man, woman, and child in this country. Furthermore, the harms to patients caused by overuse of medical services can be immediate and dramatic or delayed for years after the treatment.

The writers of this editorial call for manuscripts from students of medicine, at virtually all levels of education, in which they should describe a time when overuse has resulted in harm or narrowly missed causing harm to patients. The writers describe how routine preoperative chest X-rays can result in harm to patients and are not supported by evidence. It's more like a tradition of medical practice. The writers are seeking observations from fresh medical minds that are willing to challenge fossilized and costly practices. I would note that patients have a role in this: if your doctor proposes a test, a treatment, or a prescription, ask what difference that will make to your health outcome. Insist on a clear answer that includes consideration of alternatives. Patient-centered care is about you making informed choices and not about how many overused treatments you can be sold.

Overuse of Pap Smears in Older Women

In my December, 2013 Newsletter I wrote about the $1000 Pap test, which historically has sought to identify cervical cancer at an early stage when it is treatable. This past month an article appeared that asks how often Pap tests are performed in circumstances where evidence-based guidelines call for no Pap testing.[2] Since 2003 guidelines have called for no Pap test when: 1) the woman has no cervix following a hysterectomy, or 2) the woman is more than 65 years old and has had recent, normal Pap test findings.

The investigators used data from the 2010 National Health Interview Survey intended to be representative of the entire US population. They found that 65% of the women that had had a hysterectomy had had a Pap test since their hysterectomy. Of the women that were older than 65 and had not had a hysterectomy, 58% reported that they had had a Pap test in the past 3 years. The authors note that overuse of the Pap test continues despite evidence-based guidelines to the contrary. Their findings suggest that about 14 million women received testing against guidelines. At a basic cost of $100 per test (from my quick web survey), this amounts to $1.4 billion misspent. If you are a woman fitting either of the criteria above, challenge your doctor if she recommends a Pap test.

Kidney Stenting of No Value

One of the most egregiously overused medical procedures in patients with stable angina is the stenting (inserting an internal sleeve) of coronary arteries without trying optimal medication therapy alone. Given that background, I was not too surprised to see a new study asking if stenting the renal artery when added to medical therapy was any better than medical therapy alone.[3] The study involved about 950 patients with hardening (stenosis) of the renal arteries.

The investigating team, consisting of 18 medical experts, randomly assigned patients to receive stenting and optimal medical therapy or medical therapy alone, and then followed the outcomes for a median of 43 months. The measured outcomes were as follows: 1) composite of lethal events associated with cardiac or renal events, and 2) lethal events from all causes. As measured by either of these outcomes, there was no difference in those given the stenting and those that did not receive a stent. If you are told you have renal artery stenosis, ask hard questions before you allow them to stick a stent in your beleaguered artery.

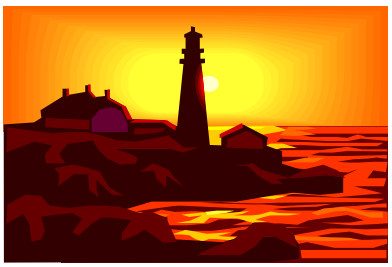
Improvements in Patient Safety

Well documented improvements in nation-wide patient safety are not easy to find; however, it appears that a large team of medical investigators has been able to show that in some ways patient safety improved from 2005-2006 to 2010-2011.[4] The investigators looked at medical records available in the Medicare Patient Safety Monitoring System (MPSMS) for more than 60,000 hospitalizations over the years in question. They searched the records for 21 standardized indicators of adverse events such as drug induced events, hospital acquired infections, pressure ulcers, and kidney injury from contrast media. They organized the original reasons for hospitalization into 4 categories: 1) heart attack, 2) heart failure, 3) pneumonia, and 4) surgery.

The years of the study were separated into three periods of 2 years each as follows: 2005-6, 2007 and 2009, and 2010-2011. There were no records available from 2008. As measured by adverse events per 1000 hospitalizations, there seemed to be reductions in adverse events associated with care for heart attack from 377 to 245 and in association with heart-failure care from 221 to 174; however, there were no demonstrated decreases in adverse events associated with care for pneumonia or surgical procedures. I'm a little suspicious of the methodology because the way records were found and assembled by the MPSMS changed from the 2005-2007 to the 2009-2011 periods as the federal agency responsible for the system changed. None-the-less, this appears to be modest good news for all those concerned about patient safety.

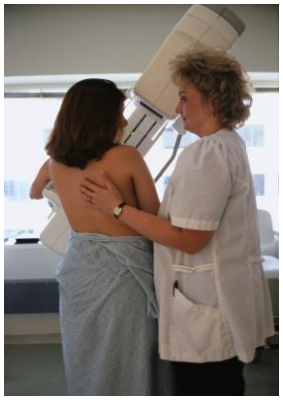
Medical Guidelines -What Next?

I often criticize physicians for failing to follow evidence-based medical guidelines promulgated by responsible organizations (http://www.guideline.gov). The fact is that some of the 2,500 "approved" medical guidelines are tainted by biased panels.[5] An MD surveying the situation noted that one of the primary sources of bias appears when guidelines are prepared by professional societies that receive much funding from medical industry sources or there are undeclared financial interests in panel leaders. An example of potential bias high in the ranks of those looking after healthcare quality has been surfaced by ProPublica involving the National Quality Forum, a top-level group that sets benchmarks for healthcare quality in hospitals (NQF Conflicts). In my opinion, there should be a grading system for all medical guidelines so physicians can readily determine the extent to which bias was controlled when the guideline was written. In response to the 2011 Institute of Medicine (IOM) report entitled "Clinical Practice Guidelines We Can Trust" (IOM Trust Guidelines) the AHRQ is changing (improving) its inclusion criteria to make the guidelines more evidence based. This begins in June 2014 (Guideline). Once the guidelines are scrubbed of bias, perhaps we can hope that more physicians will start following them.



Mammography as Big Business

If you read my newsletters you know that there has been controversy over when to begin screening for breast cancer, and you also know that there are substantial risks associated with overuse of mammography screening. A group of investigators ask how much money is being misspent each year by "intense" annual screening compared to screening as recommended by the US Preventive Services Task Force (USPSTF).[6] They modeled 3 ways of screening for breast cancer:



- Annual screening from ages 40 to 84
- Biennial screening from ages 50 to 69
- Biennial screening from 50 to 74 with health status and risk considerations for those 40-50 or over 74 years old (USPSTF guidelines)

Assuming that 85% of eligible women are screened, the annual costs were $10.1, $2.6, and $3.5 billion, respectively. The writers point out that the USPSTF guidelines are based on scientific evidence that maximizes patient benefit and minimizes potential harm…and they are a more responsible use of healthcare dollars than the alternatives. Each woman should have a serious discussion with her doctor about mammography screening. The situation is fluid as you might know. A recent study from Canada reported in the *British Medical Journal* that lives are not saved by annual mammography screening when compared to breast physical examination alone (BMJ Mammography). Stay tuned!

How to Reduce Smoking

There is good news about smoking cessation: the prevalence dropped from 43% in 1965 to 18% in 2012.[7] This has resulted in avoidance of about 8 million premature deaths and life-span extensions for those who quit approaching a mean of 20 years.[8] The writers of a perspective article note that these days cessation strategies fail for most remaining smokers.[7] They note that use of the "e-cigarette" has increased greatly in recent years, but the life-saving value of this has yet to be proven. The writers call for higher taxes on combustible tobacco products and more restrictions on where smoking can be done. Public health officials need to communicate more effectively about the dangers of smoking. A viewpoint article pointed out that researchers have neglected to investigate how some smokers quit without assistance.[9] Most smokers final successful attempt to quit smoking is by going "cold turkey" via will power and determined personal commitment.

I might note that recently the CVS Caremark drug store chain has decided to quit selling tobacco products by October 1, 2014 (CVS cigarettes). It has always annoyed me that drug stores that are supposed to be about improving health tempt customers with tobacco products at the checkout counters where they are forced to wait. This also applies to the sales of candy and our epidemic of obesity, but that is another addiction for another time.

Troubled Peer Review in VA Hospitals

Although by most measures medical care in VA hospitals is high quality, a new report from the Government Accounting Office on the peer-review process in some VA hospitals found that in the face of an adverse event, peer review is not working well (GAO VA Peer Review). The primary weakness is that some VA hospitals were not assessing the role of individual physicians in the creation of the adverse event. In addition, triggers for further investigation were not being used as intended. This undermines the ability of the hospitals to identify clinicians that are failing to deliver safe, high-quality care.

For the Children

New studies reinforce continuing research that points to the need to control infant obesity as early as 6 months of age to give the child a good chance of not being obese later in childhood and in adult life.[10] The trend continues as a child ages such that 50% of children that are obese when they enter kindergarten will be obese by 8th grade. Obesity is defined as a body mass index at or above the 95th percentile. Parents define a child's environment before they enter school, and there are few ways to

effectively manage weight gain during the first 5 years of life without the parents' determination to manage it. There are no magic formulas here – children need good nutrition and they need exercise. Here is a link that gives general guidance for childhood nutrition as the child ages: Healthy Children. One of the most important things you can do for your little children is control their weight – it is an integral part of loving them.

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Answer to question this month: b) 2.3 years from reference #8