

Question: What is the optimal BMI range for good health?

- a) 15-20 b) 20-25 c) 25-30 d) 30-35 e) 35-40

Patient Priorities for Older Adults

One of the ongoing trends in medical care anticipates that the clinician will elicit patient preferences and respond with treatment that is concordant with those preferences. Another way to express this is called ‘patient priorities care (PPC).’ As reported in *JAMA Internal Medicine*, a large [team of investigators](#) looked for how care improved when older adults with 3 or more chronic illnesses were engaged in PPC by trained clinicians. The average was age of the control group (usual care) was 75 years and the PPC group was 78 years. Of the 366 patients studied, 64 % were women.

The authors noted that there is considerable uncertainty in how to treat such patients, so their priorities are especially important. Compared to patients with usual care, those receiving PPC were more likely to have medications stopped, were less likely to have burdensome, self-management tasks, and had fewer diagnostic tests ordered. Total clinician training in PPC included 8 hours spread over 15 months. The healthcare team needed 20-30 minutes with the patient to identify the patient’s priorities. The authors opine that the PPC approach to care is expanding and will likely result in more value-based care.

My thinking for patients is that they should expect their clinician and healthcare team to elicit their preferences and respond accordingly. A wise patient, whether engaged in PPC or not, will ensure that their preferences are heard and respected by their care team. They will also ask in-depth questions about proposed tests and procedures. Preferences mean little without information.

Attacks on the Physician-Patient Relationship

Two MDs [opine](#) in the *JAMA* that there are several threats to the physician-patient relationship. This relationship hardly needs any more threats, but several discussed by the authors were new to me. Their list of threats included the following: government and corporate intrusion with their rules to constrain physician freedom when treating patients, legal mandates from legislators that sometimes require physicians to lie to their patients (abortion being an example), NRA’s attempted marginalization of physicians who see gun violence involving assault weapons as a threat to the public, and the perceived threat that immigration officials will expect physician cooperation when seeking undocumented persons in hospitals. Requirements, such as that for extensive documentation of patient encounters, erode physician well-being and consequently erode the physician-patient relationship.



‘Not your lane’ NRA says to doctors. She died of gunshot wounds.

The authors call for physicians to organize and repel these threats. Together with patients, physicians must make their voices heard over the loss of autonomy and when ‘corporate entities dictate care.’ I’d agree with that, but I’d also declare that physicians need to do a better job of policing their own so that patients will have more trust in their physicians.

Burnout of nurses and physicians reported in studies range from 35% to 54% according to three experts who expressed their [opinion](#) about how to reduce burnout. Burned-out clinicians tend to cause more mistakes and foster poor communication with patients. The experts opine that physician burn-out may be addressed at 3 levels: clinical encounter, healthcare organization, and external factors. My sampling of the ideas expressed was as follows: routinely measure physician burn out, apply a systems engineering approach to organizations, optimize information flow in and around the organization, build the infrastructure with a clear target of patient-centered care, and facilitate physicians getting mental health help without sanction.

My opinion is that unless we abandon the commercial model of healthcare, little is going to change. On the other hand, one could envision a commercial model of healthcare, but it would have to be fully transparent, something that is unlikely to happen. In the meantime, physicians, nurses and patients are trapped together in a swamp of commercialism and secret keeping.

Depression Screening

In the ‘Clinical Review and Insights’ section of *JAMA Insights*, an MD wrote about a simple depression screening tool called PHQ9, which was [originally proposed in 2001](#). Depression tends to be associated with folks who have a variety of physical comorbidities. Many physicians feel that primary care providers do not emphasize enough screening for depression. The author is a copyright owner of depression scales that have been licensed to industry. The scale provided is copyrighted by Pfizer, just so you know. The scale is useful for self-screening or monitoring the degree of depression. It is not intended as a tool for diagnosis of depression.

The 9-Item Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself

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^a Possible responses included the following: not at all, several days, more than half the days, and nearly every day.

The box shows the questions and the 4 levels of response. The review author’s opinion is that this scale tends to overestimate the severity of depression compared to other scales. If you wish to score yourself, here is a link on how to do that: http://www.cqaimh.org/pdf/tool_phq9.pdf.

Remember, any score you find that concerns you should be discussed with your primary-care doctor.

Social Determinants of Health

There is growing recognition that attention to social factors must become more integrated into the framework of health care. A new report from the National Academies of Science, Engineering and Medicine was described by an MD in an [opinion piece](#) in *JAMA*. She notes that the key factors in social health include housing, food and transportation. She gives a five step summary of how to address transportation needs within the framework promulgated by the Academies’ report.

In summary, these are as follows: ask patients about transportation needs, develop other options besides in-person care, provide transportation vouchers, invest in community ride sharing, improve the community transportation system. There may need to be workers dedicated to integrating social care with health care, more financial resources will be needed, and research into the most effective changes must be conducted.

My thoughts on this topic bring me to reflect on what my church does to address the critical needs of food, housing, and transportation. We support a food bank in our area with our labor and donations

through Interfaith Caring Ministries, we have given repairs to more than 200 houses damaged in Hurricane Harvey, and we have a ride-share program that will take people to medical appointments. Our latest outreach is to disadvantaged children in an elementary school not far from our church. About 350 children there have been identified as in need of our support. My point is to suggest that the healthcare-delivery non-system in this country should look to partnering with faith-based organizations that are already addressing the social needs that form the foundation of health. To some extent, there are already partnerships between the United Methodist Churches of the Texas Annual Conference and Houston Methodist Hospital. It's called the [Golden Care Ministry](#). The seed already has been planted, now how do we make it grow into a beautiful plant that embraces health instead of overuse of medical care? Those who would grow this model must make sure that churches do not become funnels guiding needy patients into unnecessary screening and hospital care.

Structured Treatment of Obesity

It is no secret that obesity contributes to a higher risk of many chronic conditions. Efforts to thwart the obesity epidemic in the U.S. have, at best, enjoyed limited success and are often reversed. An [editorial](#) by an MD appeared in the *Annals of Internal Medicine* describing the success that was attained in maintenance of weight loss through coaching and the electronic health record (EHR). Achieving weight loss is separate from maintaining weight loss. Many of us can testify to the challenges of maintaining any weight loss we have achieved.

The patient's EHR was used to track diet, physical activity, coaching contacts, and progress reports. Participants had lost 11% of their original body weight. They were divided into 2 groups, one with tracking and no coaching and the other with tracking and coaching. After 2 years the first group had regained gained 4.9 kg and the coached group only 2.1 kg. Coaching happened roughly monthly as guidelines specify and required an average of only 8 minutes per encounter.

The writer emphasized that primary care doctors may not be up on how to treat patients who

need to lose weight to maintain or recover health. There are two things that need to happen. There needs to be reimbursement for the process and physicians need to be educated in how to implement the guidelines for obesity treatment. If you are hoping to 'skinny up' after the holidays, ask your primary care doctor how she can help you lose weight and maintain that loss.

Treatment of *C. diff*.

Clostridium difficile (*C diff*) is a nasty gastrointestinal bacterium that is difficult to treat. A friend recently had to endure 4 courses of antibiotics before his case was finally resolved. An article in the *Annals of Internal Medicine* caught my eye when it purported to test the relative efficacy of fecal microbiota transplantation (FMT) with antibiotics. A huge team of [investigators](#) undertook a complex study in which the treatments were compared in hospitalized patients with recurrent *C diff* infection.

The team split 114 patients into 2 'matched' groups, one receiving FMT and the other antibiotics. Patients that received FMT were less likely to develop a blood stream infection within 90 days. To me, the most important data were evident in survival curves covering the 90 days after treatment. My inspection of those curves indicated that 90 % of those receiving FMT survived, whereas, only 50% of those receiving antibiotic treatment survived. On average, the length of hospitalization of the FMT-treated patients was 14 days shorter than the antibiotic-treated patients.

The authors suggest that a much larger study should be done to confirm their findings. If you are a patient with *C diff*, you should ask about initial treatment with FMT rather than antibiotics. Here is a *JAMA* Patient Page on FMT from a couple of years ago: [C diff for patients](#). Here is a more up-to-date article from a [medical journal](#).

Treatment of Constipation

In contrast to *C diff*, which causes extreme diarrhea, some of us suffer from the opposite – constipation. In the early 2000s, there were roughly 2 million visits per year to doctors for relief from constipation. An MD wrote about an [update](#) on

management of this common disorder. Guidelines were published in 2013, but there are a few newsworthy adjustments since then, if you will. These are roughly as follows: new drugs are now available for chronic constipation of unknown cause, new drugs have been approved for opioid-induced constipation, and squatting-assist devices are more readily available.

Except for over-the-counter laxatives, the more potent drugs will have to await a visit to your doctor. It seems that some are not all that effective. Discuss effectiveness data with your doctor. Let's discuss squatting. Reasonable evidence suggests that defecation is facilitated by the squatting position, which is the norm in many countries. Certain parts



of your colon get more 'aerodynamic,' so to speak. Aids, such as something to elevate your feet, are now available to assist squatting from the usual sitting position. Amazon and many others sell such devices. Good luck if you try one of these.

Improving FDA Approval of Devices

Most of us, if we live long enough, are going to have many FDA-cleared devices stuck into our bodies, either for a short time or permanently. The process used to clear most of these devices is called the 510(k), which was created by Congress in 1976. However, in 2011 the Institute of Medicine told the FDA to throw out the 510(k) process because it was hopelessly flawed. It didn't. Under the 510(k) process, the manufacturer of a 'new' device simply has to convince the FDA 'experts' that it is similar to a device that has already been cleared. When that occurs, the FDA clears the 'new' device for

marketing. No premarket studies of safety and effectiveness are required.

According to a [perspective article](#) in the *New England Journal of Medicine*, the FDA has a new process called the Safety and Performance Based Pathway. According to this approach, manufacturers pre-specify performance thresholds. This may promote competition, some suggest. This pathway is voluntary, which means it will only be used when convenient for the manufacturer (my opinion). There needs to be a way to stop manufacturers from using outdated predicate devices to gain clearance. Better capture of real-world data on cleared devices should be happening.

In my opinion, those who would improve the process have failed to hear the voice of harmed patients. Thanks to some of my colleagues in the USA Patient Network, their voices are growing louder. If you have been harmed by a device or drug, you may wish to join their voices (<https://www.usapatientnetwork.org/>).

Find past newsletters:

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

PATIENT PAGES FROM JAMA

[What is a tracheostomy](#)

[What is Norovirus](#)

[What is Dementia](#)



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**Answer to this month's question:
(b), actual best range is 19 to 25 BMI,
with some thinking 25-30 is OK.**