

Problems with Health Care

What can You Do to Improve Care

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First Edition

Mini-Medical School
North Ridgeville, Ohio

Problems with Health Care:
What Can you Do to Improve Health Care
By Raymond Lengel

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About the Author

Raymond Lengel, a certified family nurse practitioner, has worked in multiple fields of nursing. For the last seven years he has worked in primary care. In addition to being a certified family nurse practitioner he is a registered nurse with the state of Ohio.

Initially, Raymond received a Bachelor of Science degree in exercise science from the Ohio State University. Then he attained a Bachelor of Science degree in nursing from the Allen College of Nursing in Waterloo, Iowa. After working for a number of years as an exercise physiologist/registered nurse he enrolled at Otterbein College in Westerville, Ohio and got a Master of Science degree in nursing.

His writing career includes over 80 on-line continuing educational courses developed for nurses. Two articles in the magazine *Long Term Care Interface* and one in *Clinical Reviews* have been published.

He is also the author of the book, *Health Care Responsibility: The Older Adult's Guide to Surviving the Health Care System*, which was published in 2006.

Raymond has also presented a number of lectures on a multitude of health care topics including influenza, cardiac risk reduction, stress management, exercise and nutrition.

Disclaimer

This book is designed to provide basic information about the health care system and the patient's role in helping to manage his or her own health. It is sold with the understanding that each individual is unique and the book cannot provide individual advice to any one person.

This book is meant to compliment and enhance your interaction with the health care system not to serve as an alternative to medical advice or care. Utilize the system presented in this book, but be sure to work with your doctor. Your doctor is the best source of health care information for you and the unique set of conditions that are present in your body. The goal of this book is to help you with the interaction between you and your doctor, not replace it.

The author has extended every effort to make sure this book is complete and as accurate as possible. Medicine is an evolving field and ongoing research may raise some questions about some of the data in the book. There may be mistakes, both in content and typographical. The book should be used as a general guide and not as the final source for your health care information. Information is current only up to the printing date.

The goal of this book is to educate and entertain. The author and publisher will not have liability or responsibility to any person or entity for any loss or damage that have been caused by information in this book

Introduction

The World Health Organization reports that the United States has the 37th best health care system in the world (1). America's health care system is fraught with problems and its patient satisfaction is rated among the worst in the world. Even though the America's health care system is envied by the world, it ranks at the bottom of many health care indicators. In the developed world, the United States is at the bottom of the list for infant mortality and life expectancy.

Health care is not the same as it was fifty years ago. Many things have improved over the last fifty years, but the personal touch of medicine has been lost in the process. Medical science has made tremendous advances in the treatment of heart disease, cancer, infectious disease and diabetes just to name a few – but these advances have come at a cost. This chapter outlines problems with the health care system and how it has decreased quality of care.

Chapter 1: Health Care is Expensive

Health care in America is the most expensive in the world. In 2006, the United States spent \$7,421 in per capita health expenditures, which is over 50 percent more than any other country (2). Contributing to high health care cost in the United States are cost of medications, top rate medical technologies, the extensive use of diagnostic tests, salaries of doctors and hospital administrators, government regulations and increasing life expectancy.

Medications are expensive to develop and drug companies want to turn a profit. Incorporated into the price of a medication are many things above and beyond the drug itself. The science behind drug development is expensive and medications must cover the costs of producing new compounds that become established drugs. Those compounds that scientists work on for years that do not become drugs are also included in the cost of drugs. New medications need to go through a rigorous and long process to get approved. The process takes years and requires passing several strict governmental regulations.

Advertising - including commercials, drug representative salaries, perks to doctors such as pens, continuing education courses and meals - are included in the cost of medications. Drug companies must also turn a profit to keep their stockholders happy and the profit makes sure that the company continues to have money to develop new drugs for the future.

Similarly, the development of top medical technologies is expensive. Like the cost of drugs, technologies cost money to develop and use. Medical technologies can make tremendous improvements in patient care and outcomes but places a financial burden on the health care

system. A single MRI scanner costs over one million dollars and a single scan costs the patient or insurance company about one thousand dollars.

The reliance on expensive diagnostic procedures defines the American health care system and contributes to the increased health care costs. For example, chest X-rays are commonly performed on patients with cough. While many times this is a necessary diagnostic exam to rule in pneumonia or a flare of congestive heart failure, the test is often ordered when it is not necessary. Multiple reasons –including doctors not spending adequate time performing a history and physical exam, fear of litigation and patient demand – account for the over reliance on diagnostic tests. A complete history and physical exam done by a health care provider can sometimes replace the need for many diagnostic tests but many health care providers feel more comfortable ordering a diagnostic test instead of spending the time to perform a good history and physical exam.

In addition to the direct cost of the tests, many tests discover abnormalities that turn out to be a false. When tests turn up with a positive result, but the results are wrong they are called false-positive results. In order to determine the significance of the abnormalities, the physician needs to run more tests and sometimes initiate treatment.

Doing unnecessary tests based on the results of these false-positives contributes to not only increased cost, but also increased risk for the patient. Many tests have risks and can lead to complications that not only lead to more cost but may harm or kill the patient. Today's health care system focuses more on diagnostic tests than on clinician knowledge not only because doctors are more comfortable with this approach but also because it reimburses better. Procedures are grossly over-reimbursed by insurance companies and the financial responsibilities are removed from the doctor and patient.

Defensive medicine is another factor driving up the cost of medical care. The litigious society that we live in makes it necessary for doctors to cover all of their bases – by practicing defensive medicine. Delay in diagnosis is a common reason physicians are sued. Because of this, doctors are more prone to order expensive tests to rule out any possibility that a diagnosis can be missed. The practice of defensive medicine costs the American medical system billions of dollars a year.

Malpractice, another malady of health care, is driving up costs. Medical fees are higher partly in response to doctors having to pay higher malpractice premiums. Lawsuits are on the rise for a number of reasons such as unrealistic expectations of the patients, few patients are completely

informed of all possible outcomes, and the more predatory efforts of lawyers. Lawsuits in health care are necessary to keep doctors practicing safely but, nonetheless, there are many frivolous lawsuits.

Doctor's salaries are increasing especially among specialty doctors such as cardiologists and gastroenterologists. Oversupply of specialists contributes to the rising health care costs. These specialists are eager and enthusiastic to carry out expensive medical procedures because these procedures result in good payments to the doctor.

A variety of other facets of the American health care system increase costs. Competition for patients' health care dollars contributes to the health care systems participating in advertising – which increases costs. Large hospitals employ many administrators with salaries topping 100,000 dollars with these costs being passed on to the consumers. Insurance plans and government regulations increase the amount of paperwork and administrative costs. Health care institutions have to pay employees to complete this paperwork and other administrative detail.

The use of the emergency room as a primary care service is a costly form of care. Emergency room physicians do not know the patients and are more prone to ordering expensive tests and treatments.

Health care costs are increased in older patients. Older patients are sicker than younger patients and are higher utilizers of the health care system. Older patients have more chronic diseases; which translates into more dollars going into the health care system. Chronic disease contributes to health care costs by increased doctor visits, hospitalizations, medications and treatments.

Greed

Greed has inundated the health care system. Doctors seeing 6-8 patients an hour have replaced the old image of Dr. Marcus Welby sitting down and spending thirty minutes with each patient. Unfortunately, economic incentives are built into our current medical system and the American medical system is more of a business model than a caring model.

The business aspect of the medical system is disturbing. Doctors are often limited partners in the hospitals or clinics that they work at so they can help keep a financial eye on the system. Administrators are offered lofty bonuses to turn a profit. Methods used to make a profit often involve cutting staff that are front line workers directly responsible for patient care. This creates more stress on the already overworked staff resulting in a decreased quality of care.

Fewer primary care doctors practice today. Primary care doctors - family practice physicians,

internists, general practitioners and geriatricians - are responsible for handling basic health care concerns of their patients. Primary care doctors are essential gatekeepers to controlling health care costs. Due to the lower reimbursement to primary care providers, many physicians are going into specialty practice. Specialty procedures and surgeries are better reimbursed than routine follow up care. The average specialist commands a salary of one hundred thousand dollars a year more than the average primary care doctor.

Doctors want to be rewarded financially for the years of hard work they put in including four years of college, four years of medical school and 3-5 years of residency. Medicine is not as lucrative as it used to be – due to decreased reimbursement and increased malpractice premiums. Doctors have to see more patients to make the same amount of money.

Insurance Companies

Insurance companies have changed the face of medicine. Due to the extreme expense of medical care in the United States it essential to have health insurance. Unfortunately, over 45 million Americans are without health insurance. Health care is expensive even with health insurance; the deductibles and co-pays can add up to tens of thousands of dollars per year. While insurance is necessary in today's health care system it does limit the care many people receive. Insurance companies are business venues and are out to make a profit, consequently they put limits on what medical personal can do to care for the patient. Most insurance companies limit hospital stays, determine which medicines and services they can receive and even which doctor patients can see.

People with the intention of making a profit run insurance companies. Insurance brokers are highly motivated by high commission rates and caring for patient's medical needs are often not the top priority. Insurance company administrators, who often do not have a medical background, are making medical decisions. Insurance companies often preclude potential clients based on pre-existing conditions.

Managed care companies have changed the way that medicine is practiced. Doctors are often very frustrated in being limited in the testing they can perform because of reimbursement issues. The goal of managed care is to keep costs down by focusing on preventative services such as immunization and health screenings. While managed care has saved the health care system money, there are many justified concerns with the system. Physicians working for the system have less control over what can be ordered. Extensive paperwork is often involved in

getting certain procedures and referrals approved.

Capitation is a system that saves a lot of money. It involves giving the primary care provider a set amount of money for each patient in the health care plan. Spending more than a set amount of money on the patient results in a depletion of the primary care provider's salary. Spending less than the set amount provided by the insurance company results in a profit for the primary care provider. Under this system there is an incentive to control costs and limit the amount of care each patient receives. This forces the primary care provider to heavily consider the cost when ordering a test. This reduces the number of expensive tests or procedures ordered. This system will bring out a new type of greed: the doctor and health care administrator withholding care to turn to profit.

Debt from health care is a common cause of bankruptcy. It is estimated that 45.8 million Americans will die early or suffer because of lack of health insurance (3). This happens because people may wait to obtain health care - for fear of not being able to pay - until the last minute. This can occur in patients with adequate health insurance. Due the high co-pays and deductibles many insured patients wait until the last minute or avoid necessary follow up care. On the other hand, over utilization causes insurance companies to increase co-pays and deductibles. Many doctors refuse Medicare and Medicaid insurance if they can get enough patients on other insurance plans.

Chapter 2: Quality of Care is Poor

Background American adults frequently do not receive recommended health care. The extent to which the quality of health care varies among sociodemographic groups is unknown.

Methods We used data from medical records and telephone interviews of a random sample of people living in 12 communities to assess the quality of care received by those who had made at least one visit to a health care provider during the previous two years. We constructed aggregate scores from 439 indicators of the quality of care for 30 chronic and acute conditions and for disease prevention. We estimated the rates at which members of different sociodemographic subgroups received recommended care, with adjustment for the number of chronic and acute conditions, use of health care services, and other sociodemographic characteristics.

Results Overall, participants received 54.9 percent of recommended care. Even after adjustment, there was only moderate variation in quality-of-care scores

among sociodemographic subgroups. Women had higher overall scores than men (56.6 percent vs. 52.3 percent, $P < 0.001$), and participants below the age of 31 years had higher scores than those over the age of 64 years (57.5 percent vs. 52.1 percent, $P < 0.001$). Blacks (57.6 percent) and Hispanics (57.5 percent) had slightly higher scores than whites (54.1 percent, $P < 0.001$ for both comparisons). Those with annual household incomes over \$50,000 had higher scores than those with incomes of less than \$15,000 (56.6 percent vs. 53.1 percent, $P < 0.001$).

Conclusions The differences among sociodemographic subgroups in the observed quality of health care are small in comparison with the gap for each subgroup between observed and desirable quality of health care. Quality-improvement programs that focus solely on reducing disparities among sociodemographic subgroups may miss larger opportunities to improve care.

Steven M. Asch, M.D., M.P.H., Eve A. Kerr, M.D., M.P.H., Joan Keeseey, B.A., John L. Adams, Ph.D., Claude M. Setodji, Ph.D., Shaista Malik, M.D., M.P.H., and Elizabeth A. McGlynn, Ph.D. Who Is at Greatest Risk for Receiving Poor-Quality Health Care?

NEJM; 2006; 354(11): 1147-1156.

Virtually every person in the United States is at risk of failing to receive needed care regardless of race, gender, income or insurance status, according to a RAND Corporation study published today in the New England Journal of Medicine.

The study, the third installment of the largest and most comprehensive examination ever conducted of health care quality in the United States, finds that while some disparities in care exist they are small relative to the gap between what everyone needs and what they are receiving.

Two previous landmark publications from RAND Health documented that Americans receive just half of recommended care no matter where they live. Today's report represents the most comprehensive evaluation to date of the relationship between individual socio-demographic characteristics and multiple areas of quality of care. It shows that people in all socio-demographic groups experience deficits in receiving needed care, but the relative performance varies by the aspect of care examined.

“ Differences exist. But they pale in comparison to the chasm between where we are today and where we should be,” said lead study author Steven M. Asch, M.D., of RAND, the Veterans Affairs Greater Los Angeles Health Care System, and the University of California, Los Angeles. “ These findings tell us that no one can afford to be complacent, and they underscore that the quality-of-care problem in this country is profound and systemic.”

According to the study, which assessed preventive services and care for 30 acute and chronic conditions that constitute the leading causes of death and disability, participants received about 55 percent of recommended care. This is despite the fact that recommended care for these conditions is widely known and accepted.

Women More Likely To Receive Recommended Preventive Care; Younger And Wealthier Score Better For Screening

The study found that:

- Women received a higher proportion of recommended care than men (57 percent versus 52 percent).
- Women were more likely than men to receive preventive services (58 percent versus 50 percent) and needed chronic care (58 percent versus 55 percent).
- Women were less likely than men to receive needed acute care (52 percent vs. 58 percent).
- Younger and wealthier participants were more likely to be screened, but less likely to receive follow-up care than older participants.
- Adults under age 31 were significantly more likely to receive preventive care than those older than 31.
- Those aged 31 to 64 received significantly better chronic care than those under 31 (57 percent versus 51 percent).
- Those with annual family incomes over \$50,000 had quality scores that were just 3.5 percentage points higher than those with incomes less than \$15,000.

The authors found that insurance status had no real effect on quality. Insurance “ is not sufficient to assure appropriate use of services,” write the authors. In fact, in situations where everyone has equal access, disparities in care according to race or ethnic group are often reduced or even reversed.

Blacks Fare Better Overall and With Chronic Disease Care; Hispanics More Likely To Receive Screening

The relationship between personal characteristics and care received is highly complex and often condition-specific, according to the authors. For example, they note that other studies have demonstrated disparities in care for blacks associated with invasive and expensive procedures, such as kidney transplantation or coronary-artery bypass graft surgery. But the RAND Health study, which assessed a broader range of care including more routine care, showed that blacks had higher scores than whites on several indicators.

According to the study:

- Overall quality scores for blacks were 3.5 percentage points higher than for whites.
- Overall quality scores for Hispanics were 3.4 percentage points higher than for whites.
- Blacks had higher scores than whites for chronic care (61 percent vs. 55 percent).
- Blacks had higher scores for treatment than whites (64 percent vs. 56 percent).
- Hispanics were more likely to receive screening than whites (56 percent vs. 52 percent).

The authors noted that participants in the study had at least one encounter with the health care system in two years, indicating some minimal access to care. However, access alone was not enough to guarantee the appropriate delivery of care.

“ We found that once patients get in the door they are likely to experience another set of barriers to receiving needed care,” Asch said. “ Policies to improve access, while critically important, will not by themselves fix the quality problem.”

“ The results of our study will be surprising to some people, but the findings make it clear that the quality problem affects all of us,” said Elizabeth McGlynn, Ph.D., associate director of RAND Health and senior author of the study. “ This tells us that the U.S. health care system is unreliable and cannot guarantee that patients—rich or poor, white or black, insured or uninsured—will receive the right care at the right time. We need to fundamentally redesign the health system to

ensure that no matter who you are or where you go for care you will get what you need.”

The study, funded by the Robert Wood Johnson Foundation, used a state-of-the-art methodology that involved both telephone surveys and reviews of patients' medical records from all providers seen during the two-year study period. Nearly 7,000 adults in 12 nationally representative metropolitan areas participated in the study, which evaluated performance on 439 indicators of quality for 30 acute and chronic conditions such as urinary tract infections, diabetes, asthma, high blood pressure and heart disease—along with preventive care.

In addition to Asch and McGlynn, collaborators included: Eve A. Kerr, Veterans Affairs Ann Arbor Health Care System and the University of Michigan; Joan Keesey, John Adams, and Claude Setodji of RAND; and Shaista Malik of the University of California, Irvine.

Chapter 3: Health Care is not Convenient

Much of the recent debate about how to reform our inefficient, two trillion-dollar health-care system has revolved around who should pay, but the problem will not be fixed until we find ways to increase access and reduce costs that have been rising for many years at more than twice the rate of inflation.

One of the most promising developments is the emergence of retail-based "convenient care" clinics that are providing consumers with easier access to high-quality, routine health care at affordable prices. There are about 400 such clinics today and could be several thousand more in the next few years, but their growth is being threatened by burdensome regulations in some states and opposition from some corners of organized medicine.

Convenient care clinics are small health-care facilities with new brand names like RediClinic, MinuteClinic, and Take Care Health Clinics. Most are located in high-traffic retail outlets with pharmacies, such as Wal-Mart, CVS and Walgreen stores. Regional health-care systems have also opened retail-based clinics in their service areas, either directly or in partnerships with independent operators. These clinics generally are staffed by certified nurse practitioners who diagnose, treat and prescribe medications for a limited set of common ailments, such as strep throat and ear infections. They also administer health screenings, medical tests, immunizations, basic physical exams and other preventive care.

Convenient care clinics have been embraced by consumers, who give them consistently high marks for patient satisfaction: 97% of the more than 4,000 RediClinic patients

surveyed this year said they would recommend RediClinic to their relatives and friends. This is because the clinics are delivering something that is all too rare in our system -- convenient and affordable health care.

The quality of care at convenient care clinics stems from their use of nationally certified nurse practitioners, who are registered nurses with master's degrees or comparable advanced training. Research over the past 30 years has consistently shown that the primary care provided by nurse practitioners is comparable in quality to that provided by physicians, though nurse practitioners are still required to collaborate with local physicians in most states.

Patients who have conditions that are outside of convenient care clinics' limited scope of practice, or who need ongoing care, are referred to local physicians, and nurse practitioners use evidence-based treatment protocols and electronic medical-record systems to standardize care and facilitate continuity of care when other clinicians are involved. According to a recent study conducted by the RAND Corporation, Americans receive evidence-based care only 55% of the time at conventional health-care delivery outlets. MinuteClinic's recent analysis of 58,000 sore-throat cases seen at their clinics showed that the diagnosis and treatment conformed to evidence-based guidelines 99.15% of the time.

Convenience is assured through the location of the sites and the fact that they are open seven days a week, including extended hours on weekdays. No appointments are necessary, and visits take only about 15 minutes due to the clinics' limited set of services. The clinics' location in stores with pharmacies provides additional convenience because patients can go across the aisle to get their prescriptions filled rather than having to make separate trips for this purpose.

Treatment for most common ailments ranges from \$40 to \$70 and preventive services start as low as \$15, significantly less than what most physicians, urgent care clinics or emergency rooms charge. Indeed, research shows that as many as 50% of the people who seek care at overburdened emergency rooms could be treated much less expensively in convenient care clinics. Prices are prominently displayed so patients know what they will pay before they are treated, and visits are covered by a growing number of insurance plans, including Medicare.

Applicable regulations vary by state. In some states they are already compatible with the goals of convenient care clinics to increase health-care access and affordability, or there are legislative efforts underway to make them more so. In other states, however, regulations discourage convenient care growth. They may prohibit the "corporate practice of medicine," which prevents non-professional operators from employing nurse practitioners or owning equity in the clinics, or unreasonably restrict the number of nurse practitioners that can be supervised by a physician.

In Texas, for example, a physician can supervise a maximum of only three nurse practitioners and the physician has to be on-site for 20% of the time a clinic is open, even though he or she is not treating patients. This needlessly increases the clinics' cost structure, which creates higher prices for consumers and third-party payers. Moreover, it

unproductively ties up physicians who are in short supply and could be attending to patients with more serious conditions.

Although the medical community was suspicious of convenient care in the beginning, many physicians and professional organizations changed their view when they saw how rapidly consumers embraced the concept and how operators provide high-quality care within a limited scope of practice, treat many patients who do not have established physician relationships (an estimated 30% of all convenient care patients to date), and refer many others. The American Academy of Family Physicians, which represents more than 94,000 family practitioners, recognized that convenient care clinics were filling a need. Rather than opposing the clinics, it published standards of care that it suggested convenient care operators should follow. Operators gladly complied because they had been meeting or exceeding these standards. The Convenient Care Association, which represents more than 20 of the largest operators, subsequently published more stringent standards that their members are now required to meet.

Some physician organizations, however, including ones in Illinois and Massachusetts, are pushing for new regulations that would impede the growth of convenient care clinics through expensive permitting requirements (which physician practices do not have to face), further limitations on the number of nurse practitioners that an individual physician can supervise, and prohibitions against advertising that compares the fees of convenient care clinics with those of physicians. This is exactly the kind of price transparency our health-care system needs. In addition, the American Medical Association passed resolutions at its recent annual meeting that push for government intervention, legislation and other measures that could curtail the expansion of convenient care clinics.

Opposition to convenient care from some parts of the medical community is made under the pretext of wanting to ensure quality and continuity of care, which is a legitimate but thus far unfounded concern. But the opposition is also about wanting to maintain the status quo even in the face of rapidly escalating costs and a growing shortage of primary-care physicians.

While resistance to disruptive change is understandable, it does not diminish the fact that the status quo in health care is not working for millions of consumers and that it is economically unsustainable even if it were. Instead of opposing convenient care, physicians should be working collaboratively with operators -- as many physicians are today -- to fill the critical need that all Americans share for easier access to high-quality, affordable health care.

Chapter 4: Health Care is Fragmented

Information does not always follow patients – there is no one place that knows all about your health. Fragmented health services are largely responsible for health care information not being in one place. Fragmentation is the use of multiple medical specialists or medical systems to care for one individual. One doctor caring for all of your medical needs is not the norm in today's health care setting. Fragmentation of health care is one by-product of the health care monster in

America. Fragmentation leads to duplicate medications and services, which is not only costly, but also potentially harmful or deadly.

An individual with diabetes, heart failure, prostate cancer and depression could be seeing six different doctors including an endocrinologist (doctor for diabetes), cardiologist (heart doctor), urologist (doctor of the urinary system), oncologist (cancer doctor), psychiatrist and a primary care doctor. With this many doctors treating the patient there is risk for duplication of services – such as two different doctors doing the same test or two different doctors prescribing similar or duplicate medications – and too few tests being run (because one doctor assumes the other is running the test). Poor communication between the specialists is commonplace and one specialist often has no idea what the other specialist is doing. The use of many health care providers often leads to use of many drugs. It is critical that each health care consumer helps monitor medicines to assure there are no duplications of medicines or drugs that interact with one another. It is also essential that each doctor knows which medications each of his patient's are on.

Medical specialists, experts on any one-body system, are very valuable. With the plethora of research published every month, keeping up to date is not possible for any one doctor. There are over 4000 biomedical journals and over 500 new medicines or new uses for old drugs per year making it impossible for doctors to stay up to date on all areas of medicine. Many general physicians worry about the scope of their practice with all of this new data and inability to keep up with all of the new information.

While specialists are great resources, caution must be instituted when seeing specialists. Providing continuity in the health care system falls on the shoulder of each individual consumer of health care. Each individual needs to actively participate in his or her health care to help assure continuity. The first step is to communicate effectively within the health care system. The use of the medical record system outlined in this book is an important step in keeping information organized and a primary step in health care responsibility.

Primary care doctors often take care of their own patients in the hospital, but this takes away from their office practice. Consequently many consult hospitalists. The hospitalist is a doctor specializing in care of the patient who is admitted to the hospital. These groups of physicians are experts in care of hospitalized patients and provide excellent care.

The hospital is a time when the body is in a broken down state and care needs to be maintained or dire consequences will ensue. While the hospitalists does a good job at caring for

hospitalized patients they are typically not familiar with their patient's medical history.

It is critical to convey an accurate report of the medical history to the hospitalists. When being care for by a hospitalists, the use of the personal medical system is critical – it may mean the difference between life and death.

Doctor Appointments

Doctor appointments fall below the expectation of many patients. The average office visit is approximately 15 minutes (and many patients would argue the average visit is much less than this). These 15 minutes include the health care provider reviewing the chart, talking to the patient, examining the patient, charting, answering questions, filling out forms and giving out prescriptions. Time limits placed on office visits do not allow the physician to spend adequate time with the patient.

Many patients complain about long waits within the health care system. Long waits in the emergency room or doctor's office is considered normal. Many physician offices require an initial visit so a complete history and physical exam can be preformed before being seen for urgent problems. Doctor offices often have waits of one to two months for this initial appointment – they are more time consuming. When an individual needs to see the health care provider for an acute illness, the doctor's office will not see the patient until this initial visit is carried out.

Patients need to learn how to best utilize office visits. Time constrains limit the time health care providers have to discuss medical care with patients. The health care consumers need to maximize this short time with the doctor. This includes being organized and knowing how to communicate with the health care system. Some doctors practice under the assumption that doctor knows best and do not feel it is necessary to share all information with their patients.

Chapter 5: Health Care is a Business Model; Not a Caring Model

Medicine is big business that is driven by money and patient care is sometimes a secondary goal. It may seem that this would be an easy feature to spot but it is not. Some physicians see 6-8 patients an hour, spending only five minutes per visit. The end result is poor quality health care.

The market-driven health care system does not reward hospitals or physicians that care for the least among us. Hospitals that have a high indigent care load find it more difficult to earn dollars for reinvestment in facilities and technology to remain competitive. Success in a pure business model of health care may only be defined as operating margin.

And considering that the side effects of many of these drugs are more threatening than the underlying disease, why do we -the FDA, Congress, us as Citizens, continue to allow conditions, programs and processes that are so obviously at the expense of the American public, the health care consumers like the retired and disabled?

Everybody in the health "food chain" blames the other guy; remember the old criminal defense, "SODDIT" (Some Other Dude Did IT)? When nobody takes responsibility, nothing gets done. The one "cure" that almost everybody with a vested interest seems to agree on is some version of Universal Health Care, with "Uncle" paying the bills.

That won't work, just drives up costs. And we can't keep saying the government (meaning taxpayers) just has to pay for it. It is only when we get individual responsibility for health care decisions and personal responsibility that we will get the system under control.

As long as somebody else pays, everybody wants a piece, and the bigger the better. Lots of people remember when "insurance" meant just that-you paid your premiums, the insurer paid the bills. What went wrong? Lots of people can add, and the cost of a family of four health premium on average is over \$8000.00 a year, in some areas and groups, up to \$12,000, even more?

Who can pay these ridiculous premiums, and then have to pay deductibles and have caps on benefits even after all that? How much individual care would that \$8,000 buy if consumers made the decisions? I'll bet if we gave consumers the chance it would surprise us, as long as the delivery system were structured along modern designs.

Yes, the "health denial" system needs reform; yes, there is a structure which would use free market economics to control cost, while INCREASING the quality of health care and delivery.

And, how about still using mostly hundred year old infrastructure in the health care industry, when we have a new twenty-first century capability to deliver more, for less. (If the [Internet](#) and Computer industry changed at the same rate as the medical industry, we'd still be using Abacus, sheepskins and quills)

And, if the system were restructured, doctors might welcome Medicaid and Medicare (Universal care) patients, rather than finding ways to "beat" the system to get paid. We can do better; we must, if the system is to survive for all of us.

Throwing more taxpayer money at the problems is just not going to work without consumer-driven reforms. There is a solution that would work, if we can get past the "whose ox is being gored" phenomenon.

Here it is.

First, nationalize the Health Insurance industry, or make them part of the restructuring process by integrating insurance with the health care delivery process through ownership of health care facilities. Insurers collect hundreds of Billions of dollars in premiums and huge profits for managing the claims process and making non-medical coverage decisions, some unfairly, some efficiently, if not considerately.

Second, change the delivery of health Care by instituting a national system of privately-owned walk-in clinics, utilizing accepted national standards of health care, and staffed mostly by fully trained and licensed Registered and Practical [nurses](#), along with salaried medical professionals, including an Internists or GPs, a Pediatricians, and an OB/Gyns. These folks would be rewarded by typical private business incentives like profit sharing, bonuses and so on, based on typical health care measurement standards like outcomes, quantitative and qualitative standards of health status

In areas where privately owned clinics do not choose to operate, and there should be few of these considering the profit potential, government-sponsored clinics with salaried professionals would practice. It is not hard to budget this

approach since all the logistics are known(number of people to be served per clinic, square footage and equipment needed, minimum staffing requirements).

These are NOT hospitals, but clinics who can take advantage of the volume of "customers" to achieve economies of scale. Since these clinics are the "first line" in health care, they would be the emergency centers as well, able to diagnose conditions, and forward patients to hospitals as necessary. This would be the Intake point-of-contact for indigents, immigrants and others, whose use of high-cost emergency care in place of doctors or other medical alternatives are a significant upward cost driver. This would also be a good place to initiate home country bill-back for care of illegals. No refusal of care, just a better method of delivering needed care, and a way to make someone responsible for the cost.

Chapter 6: Chronic Disease is out of Control

- Percent of adults age 20 years and over with high serum cholesterol: 16% (2003-2006)
- Mean serum cholesterol level for adults age 20 years and over: 200 mg/dL (2003-2006)

Source: [Health, United States, 2008, Table 72](#)

- Percent of visits to office-based physicians with cholesterol measure ordered or provided: 7.1%
- Percent of visits to office-based physicians with comorbid hyperlipidemia indicated on the medical record: 13%

Source: [National Ambulatory Medical Care Survey: 2006 Summary, Tables 15, 16](#)

- Percent of noninstitutionalized adults 20 years and older with diabetes (diagnosed or undiagnosed): 10% (2003-2006)
- Percent of noninstitutionalized adults 20 years and older with diagnosed diabetes: 7.7% (2003-2006)
- Percent of noninstitutionalized adults 20 years and older with undiagnosed diabetes: 2.5% (2003-2006)
- Number of deaths: 72,449
- Deaths per 100,000 population: 24.2
- Cause of death rank: 6

- Number of noninstitutionalized adults with diagnosed heart disease: 25.1 million
- Percent of noninstitutionalized adults with diagnosed heart disease: 11%
- Number of deaths: 631,636
- Deaths per 100,000 population: 211.0
- Cause of death rank: 1

Percent of non-institutionalized adults ages 20 and over: 32%

Percent of non-institutionalized adults ages 20 and over: 32%

- Number of visits to office-based physicians with hypertension as primary diagnosis: 35.7 million

Source: [National Ambulatory Medical Care Survey: 2006 Summary, Table 12](#)

- Number of visits to hospital outpatient departments with hypertension as primary diagnosis: 3.9 million

- Percent of noninstitutionalized adults age 20 years and over who are overweight or obese: 66%
- Percent of noninstitutionalized adults age 20 years and over who are obese: 32%

Source: [NHANES data on the Prevalence of Overweight and Obesity Among Adults-United States, 2003-2004](#)

- Percent of adolescents age 12-19 years who are overweight: 17%
- Percent of children age 6-11 years who are overweight: 19%

Number of deaths for leading causes of death:

- Heart disease: 631,636
- Cancer: 559,888
- Stroke (cerebrovascular diseases): 137,119
- Chronic lower respiratory diseases: 124,583

- Accidents (unintentional injuries): 121,599
- Diabetes: 72,449
- Number of residents age 65 and over: 37.3 million (2006)

Source: [Health, United States, 2008, Table 1](#)

Life expectancy

- Men at 65 years: 17.2 years (2005)
- Women at 65 years: 20.0 years (2005)

Source: [Health, United States, 2008, Table 26](#)

Health status

- Percent of noninstitutionalized persons age 65 and over in fair or poor health: 25% (2006)

Source: [Health, United States, 2008, Table 60](#)

- Percent of noninstitutionalized persons age 65 and over with activity limitation caused by chronic health conditions: 33% (2006)

Source: [Health, United States, 2008, Table 58](#)

Health risk factors

- Percent of noninstitutionalized persons who currently smoke cigarettes (2006)
 - Men age 65 and over: 13%
 - Women age 65 and over: 8.3%

Source: [Health, United States, 2008, Table 63](#)

- Percent of noninstitutionalized persons who are overweight (2003-2006)
 - Men age 65-74: 78%
 - Men age 75 and over: 66%
 - Women age 65-74: 71%
 - Women age 75 and over: 63%

Source: [Health, United States, 2008, Table 75](#)

- Percent of noninstitutionalized persons with diagnosed diabetes
 - Age 65-74: 20%
 - Age 75 and over: 18%

Source: [Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2007, Appendix III, Table VII](#)

- Percent of noninstitutionalized persons with hypertension (2003-2006)
 - Men age 65-74 years: 64%
 - Men age 75 and over: 65%
 - Women age 65-74: 71%
 - Women age 75 and over: 80%

Chapter 7: Preventative Care is Pathetic

The health care system of the United States focuses more on curative care than preventative care. With the escalating costs of health care we need to invest more time and money in preventative health care. Preventative medicine either prevents disease from occurring or diagnoses problems before signs and symptoms or complications of disease arise and increases the chance for recovery. The main goals of preventative medicine are to decrease the chance of getting ill, becoming disabled or dying. Preventative medicine involves healthy eating, exercise, smoking cessation, decreased alcohol use, injury prevention, the use of diagnostic tests to catch disease early and the use of vaccines.

Insurance companies pay for some preventative services but many are not covered. The American health care system is interested in making money. More money can be made curing and treating disease than preventing disease.

America has become an obese and sedentary society. We are involved in more spectator sports than participator sports. We have a decreased use of physical education in schools. We watch more television and play more video games than exercise.

Lack of exercise is a common predecessor of disease. The implementation of a regular exercise program significantly reduced the risk of many diseases including obesity, which can lead to significant health care problems. Weight loss can provide many health benefits to obese patients including increased quality of life, decreased blood pressure, improved cholesterol and a reduction in diabetes and heart disease.

Chronic disease kills. Fortunately, chronic disease can be prevented or delayed with preventative health care. Preventative health care is a broad term that incorporates a variety of activities that prevents problems before they occur or catches them before they do too much damage to the body. Disease states can be treated easier if they are detected early. Examples of preventative health care include: exercise, good nutrition, stopping or not starting smoking, minimizing alcohol intake, receiving recommended immunizations and having recommended health screenings.

Everyone will die; but approximately 40% of deaths are preventable and related to smoking, bad diet, lack of exercise and alcohol intake. Many preventative health activities are actions you do on your own without help from the health care system; but several activities require partnering with your health care providers. For example, exercise is something you need to motivate yourself to do every day and you cannot rely on your doctor to do it for you. On the other hand, exercise sometimes requires medical clearance and stress test before it can be done safely.

General goals of preventative health care are to decrease premature death and increase quality of life, while specific goals are set for each individual. National organizations have set up guidelines for preventative health care services. The preventative health care worksheet, found in appendix A, provides some general guidelines and a way to track preventive health care.

Preventative health care is underutilized in the United States for a variety of reasons. Individuals often lack proper education about the importance of preventative health care or what it entails.

Lack of knowledge about the benefits of preventative health care limits use of these important services. The doctor often forgets or neglects to recommend preventative testing. It is therefore important that patients understand what tests they need and when they are needed, so they can act as a safety net to assure testing or treatments do not get missed.

The lack of knowledge about how preventative health care works is another barrier to getting recommended health care services. Exercise and nutrition are complex topics and many patients lack an understanding of what constitutes an exercise program or good nutrition.

Preventative medicine saves many lives so take advantage of the resources that are available. Developing a partnership with a primary care doctor is an important first step in preventative medicine. Health care responsibility involves knowing what tests you need and how to communicate this with the health care system. Being able to relay accurate information in regards to previous testing is vital in assuring you get optimal health care. This is best accomplished if you have your health care information organized. Step three of the personal

health record in chapter 11, provides a framework for you to record and track preventative health care.

What you need to know

Health care responsibility is a key element in the practice of preventative medicine. Many aspects of preventative medicine get missed within the American health care system. Do not assume that your doctor will remember to discuss, recommend or provide all the necessary measures to practice good preventive health care. While some doctors are better at this than others, most doctors simply have too many patients and not enough time to do a complete job at preventative medicine. You need to take responsibility. Many aspects of preventative medicine are completely dependent upon the individual while others require collaboration between patient and the health care provider. This next section discusses the three main objectives to preventative health care: healthy lifestyle, health screenings and immunizations.

Healthy Lifestyle

Living a healthy lifestyle is one of the most cost effective, and underutilized, ways to prevent the development or progression of chronic disease. Living a healthy lifestyle, in the American culture where a fast food restaurant is on almost every corner and it is glamorous to smoke and drink, is a challenging prospect. None-the-less, individuals who lead unhealthy lifestyles are at increased risk for death and disability.

Maintaining a healthy lifestyle is not without challenges; it can be extremely difficult. It involves changing habits that have been ingrained in your lifestyle for many years. For example, unhealthy eating habits have been embedded into many people's habits through out the years. Changing the diet to incorporate fruits, vegetables and lean meats can be very difficult. Finding sixty extra minutes in the day to incorporate an exercise program may involve major lifestyle shifts that cannot be overcome.

Health care professionals struggle with the benefit of prescribing lifestyle changes in the older adult. Many older adults are set in their ways and it can be difficult to dissuade their pattern of life that they have developed over the last 60 to 80 years. Many older adults feel that major lifestyle changes limit the amount of enjoyment they will get from life. This could not be further from the truth; lifestyle changes not only prolong life, but also improves the quality of life. Healthy lifestyle is the number one step to becoming functionally younger.

Lack of knowledge is a common barrier to practicing preventative health care. The 5-10 minute office visit you have with your doctor is not enough time to learn what you need to know

about preventative health care. The majority of information about good preventative health care needs to come from outside the medical office. The office visit is a time for you to get limited specific information about healthy lifestyles.

Two major topics in healthy lifestyle, exercise and nutrition, will be discussed at length in the next chapters.

Smoking is one of the worst things you can do for your health. Smoking is associated with many diseases including heart disease, stroke, emphysema and multiple types of cancer. Quitting smoking is one of the most important steps you can take to improve quality and quantity of life.

Health experts report alcohol in moderation can have beneficial effects on health. Excessive alcohol can have multiple negative effects including liver damage, stomach problems, and problems with balance, which leads to falls and fractures. Moderate alcohol consumption, which is defined as one drink per day for women and two drinks per day for men, may protect the heart and raise HDL or good cholesterol.

Injury prevention is a broad category that can improve quantity of life. Activities associated with injury prevention include; wearing a seatbelt, using smoke detectors/carbon monoxide detectors, home safety evaluations and setting hot water heaters to 130 degrees or below.

Chapter 8: Too Many Errors

The Institute of Medicine estimates that in 1999, 44,000 to 98,000 Americans die each year by mistakes in the hospital (1). In addition to death, other complications and increased health care costs contribute to the dire state of the American hospital system. Complications, including errors, cost the American health care system billions of dollars each year.

Hospitalization is typical and often necessary when individuals are acutely ill, but it is fraught with risks. Hospitalization is not always required to treat disease, but at other times it is the only way to go, as many disease states cannot be managed without extensive monitoring and testing. This chapter discusses the risks and ways to avoid complications and errors in the hospital. Each individual needs to be organized during his or her hospital stay and be involved in the care.

Risks of the Hospital

The hospital is a dangerous place. The risks of hospitalization can be subdivided into complications of hospitalizations, errors and iatrogenic disease. Complications are occurrences

that result from some aspect of the hospitalization. Errors are mistakes that doctors, nurses or other staff members commit. Iatrogenic disease, defined as disease produced by doctors or other health care workers, runs rampant in the hospital.

You may be thinking, "Doctors don't cause disease". Yes they do. It is extremely rare that they would do this purposely but doctors and health care providers frequently cause disease unintentionally, common examples of iatrogenic disease include infections, side effect or complications of a medication, such as major bleeding or kidney failure from a diagnostic procedure.

Complications

Complications of hospitalization are more common in the older population. Risk factors for complications in the hospital include recently living in a nursing home, older age, increased number of drugs, poor health and longer length of stay. Risk factors of physical or mental decline during a hospitalization include age greater than 75, dementia, inability to perform activities of daily living such as bathing or cooking, social isolation and poor physical functioning such inability to walk independently.

Complications of hospitalization consist of sun downing, falls, excessive bed rest, pressure sores, malnutrition and increased dependency. Sun downing, which commonly occur in those with dementia, is an increased amount of confusion often associated with agitation or other behavior disturbances that occurs at nighttime. Those without diagnosed dementia who suffer sun downing in a new environment are often diagnosed shortly thereafter with dementia. Sun downing increases the risk of problems such as falls, use of restraints (tying the patient down) or excessive use of medicine to control behaviors.

Bed rest in the hospital is commonplace. Sometimes it is necessary to prescribe bed rest but usually getting patients up and moving is the best strategy to prevent complications. Bed rest breeds dependency, which leads to further complications including debility after hospitalization. The risk is even greater in those who are older and have a baseline lower level of functioning.

The hospital is an environment where many people, with older individuals being at greater risk, lose their sense of identity. Patients are thrown out of their daily routine - not eating their own food, not sleeping in their own bed and not taking their own medicine. These changes are enough to get some patients sicker. Increased confusion is a very common problem seen in older patients when changing environments.

Pressure sores, more commonly known as bedsores, are a frequent complication of a

prolonged hospitalization. Hospitalized patients are at increased risk for pressure sores due to bed rest, poor nutrition and dehydration. Pressure sores can be prevented with good nursing care including assuring good nutrition and getting the patient up to walk. Getting up is something that many hospitalized patients do not do, especially ones who are extremely ill. If you have not been getting up, encourage the nursing staff to get you out of bed. If you are unable to get out of bed make sure you are getting turned frequently (at least every 2 hours) or placed on a specialty mattress to reduce pressure on areas of your body.

Malnutrition is common among hospitalized patients. Patients in the hospital are sick are not eating well. In addition, disease states increase the rate at which your body uses energy, so eating the amount of food you normal eat may not be enough to maintain body weight and promote healing. Eating a diet that is different then the food you eat at home often leads to a voluntary decrease in food intake and weight loss.

Bringing your own food can sometimes prevent not only malnutrition but also other illness and expense. Before doing this always check with your health care provider, as many hospitalized individuals require special diets. For example, after a stroke patients often need food that is puréed to prevent the food from sliding down into the lungs and causing pneumonia.

Falls are a frequent occurrence among hospitalized patients. Hospitalized patients fall due to weakness from illness, mobility restriction from intravenous lines, sedation due to new medicines, and getting up to go to the bathroom without assistance. Often falls result from a combination of factors such as weakness secondary to the disease process that the patient is admitted for, combined with an unusual environment.

New medications can lead to falls. For example, new blood pressure pills can result in dizziness or unsteadiness. Water pills can lead to increased urination especially at night. When the urge to urinate comes on at night a patient trying to maneuver to the bathroom in an unfamiliar environment increases risk of falls.

Taking responsibility for your safety consists of asking for help when ambulating and knowing the medicines you are on and the risk they pose for falls

Errors

Medications

Complications from medicine can be broken down into errors and side effects. Side effects are reactions that result from a medication or treatment. Many times side effects are expected but the doctor decides that the risk of the side effect is worth the benefit of the treatment. All

medicines have side effects, but some are much more dangerous than others. When taking new medicines be aware and report unusual sensations to your doctor or nurse. Some common medicines used in hospitals require special attention.

- Antibiotic can cause an infection of the intestines resulting in diarrhea or yeast infections.
- Powerful antibiotics such as gentamicin or tobramycin, can cause kidney damage or hearing loss.
- Heart medicines are a very broad class but any new drug for the heart needs to be monitored closely for side effects including low blood pressure, falls or dehydration.
- Some pain medicines – called non-steroidal anti-inflammatory medicine - can cause stomach bleeding or kidney shutdown.
- Other pain medicines – narcotics – can cause confusion, dizziness and falls.
- Prednisone, which is a steroid, is used to treat inflammation such as certain types of arthritis or lung infections. It can thin bones, raise blood sugar or cause weight gain.
- Cancer drugs have many side effects and can damage many body systems.

Errors

Errors are mistakes made by a health care professional. Most medication errors are due to lack of attention not lack of knowledge from patients and staff.

Admission to the hospital is a common place where medication errors occur. Patients are often admitted to the hospital by a physician who is unfamiliar with his or her past medical history. Therefore, the admitting doctor relies solely on the patient's report of medications when prescribing medications that the patient will take in the hospital. If the patient does not provide an accurate list of medications then he or she will not get all of the medications necessary to keep their body in balance. Patients who are admitted to the hospital are in a weakened state due to their underlying illness and typically need all of the medications that they are on at home to keep their body balanced.

Consequently, when a patient is admitted to the hospital, the patient can make a significant positive effect on the number of errors. Accurately reporting the medications that the hospitalized patient is currently taking is a critical step in preventing errors. This is best accomplished by providing the admitting doctor with your personal health care record.

Patients getting the wrong medications are another form of error common in hospitalized patients. Nurses are very busy and care for multiple patients who they are unfamiliar with. Patients getting the wrong medicines are an occurrence that can be prevented. The best way to

prevent yourself from getting the wrong medicine is to keep track of what medicines you get. Maintaining the [hospital chart](#), which is listed in appendix B and described in detail later, is one method to track your medications.

Misdiagnosis

Misdiagnosis is common in the hospital. Medicine is not an exact science; it is a combination of art and science. Coming up with the correct diagnosis is important to prevent progression of disease and the possibly death and disability that can accompany disease. Some diseases are more easily diagnosed than others. Cooperation from the patient can significantly aid the doctor in making a speedy and accurate diagnosis. Accurate reporting of the past medical history and current symptoms, asking the right questions and making sure you are getting optimal care reduces the chance your doctor will diagnose you incorrectly.

Discharge

Errors on discharge are common. When being discharged from the hospital the patient receives discharge instructions including a list of medications. Comparing this list of medicine to your personal hospital chart, that you have been keeping during your stay, can aid you in assuring there are no errors on discharge. When you are given your discharge instructions, compare the medication list with the list of medicines you were given in the hospital, on your hospital chart. If they do not match up question the discharge nurse or the doctor for clarification.

Hospitalizations are times that medications are adjusted. The patient often assumes that medications not on the list are ones that were discontinued in the hospital. Many times this is the case, but many times medications were accidentally left off. Errors occur far too commonly on discharge. Nurses, doctors and other health care professionals taking care of you are who are all very busy. Oversights and omissions occur even with the best-intentioned health care providers. Your best defense is to closely monitor your medical care. No one has your best interest in mind more than you.

Follow up appointments commonly get missed after discharge. Discharge instructions should include a scheduled appointment with your doctor or a number to call to set up that appointment. Make sure that this appointment is carried out. This can mean the difference between life and death. New medications are often started in the hospital and require outpatient monitoring to assure they are not only effective but also not causing any life threatening complications.

Discharge Steps

1. Ask every day when discharge will occur. The answer to this question may not be

known, but it is important that you are prepared for discharge and asking everyday is the first step to being prepared.

2. Meet with the doctor before you are discharged. Make sure a family member or loved one is with you to be an extra set of ears.
3. Ask the doctor to review the medication list and compare this to your hospitalized list of medication. If there is any discrepancy, question the doctor.
4. Ask the doctor to confirm follow up appointments, when it is needed and with whom.
5. Ask the doctor what symptom you should be on the look out for that would require medical attention and what to do if this occurs.
6. Ask any remaining questions
 - What signs or symptoms should I watch out for that may indicate my disease is worsening?
 - What will my recovery entail?
 - How do I reach you?

Iatrogenic Disease

Infections

Two million hospitalized patients suffer from hospital-acquired infections each year (2). Hospital induced infections are also known as nosocomial infections, which not only increase the cost and length of your hospital stay but increase the risk of dying in the hospital. Nosocomial infections cost the American health care system billions of dollars a year. Infection rates vary a lot by hospital, so it is important to be informed about which hospitals are most risky. Contact your local health department to determine which hospitals have the lowest incidence of hospital-acquired infections.

Most common types of hospital-acquired infections are urinary tract infections, severe diarrhea, pneumonia and blood stream infections. There are bacteria and viruses in the hospital that most patients have not been exposed to and are susceptible to. Most hospitalized patients have a suppressed immune system due to their illness and have a more difficult time fighting infections.

Many of these infections can be prevented. The most important step to prevent hospital-acquired infection is to make sure everyone who gets close to you washes his or her hands. It is important that you insist every person who takes care of you washes his or her hands prior to putting hands on you.

Invasive procedures, which are actions where some type of instrument is introduced into the body, may initiate infection. Examples of invasive procedures include: urinary catheterization, inserting intravenous lines and cardiac catheterizations. These procedures are typically done under sterile technique so no bacteria can enter into the body. These procedures are done by busy nurses and doctors who at times may not follow the proper technique and may introduce bacteria into the body. The hospital is an environment with a lot of bacteria floating around. This increases the risk of getting infections during these procedures.

Infections often result because a disease is spread from another sick patient. If your roommate is showing signs and symptoms of an infectious disease, ask to move rooms. Signs and symptoms you may notice that indicate infection include: coughing, diarrhea, runny nose, fever or increased confusion. Many infectious diseases are passed through the air or from touching something that the sick patient has touched or being in close proximity to someone with infection.

Diagnostic Testing

Unnecessary testing is a frequent occurrence. Diagnostic tests have risk including pain or discomfort, allergic reaction, bleeding or infection. It is imperative that you inquire about the necessity of each test that you have. Tests such as a CAT scan can save your life but it also provides a tremendous amount of radiation, which is a potential deadly side effects.

Commonly x-rays are performed to help diagnosis or rule out pneumonia but they are often not needed. Someone who presents with a runny nose, sore throat, cough and low-grade fever is unlikely to have pneumonia. In this situation an x-ray is sometimes ordered (especially in the emergency room) to rule out pneumonia even though pneumonia is unlikely. X-rays are generally safe tests but they are not completely benign as they do entail radiation exposure.

There are a number of steps that should be taken when diagnostic tests are recommended in the hospital. When the technician comes to take you for the test, you should ask, "who is this test for?" Errors may occur because the test is performed on the wrong person. Asking whom the test is for will decrease the chance of this happening. When your doctor recommends the test ask the questions listed in Table 5-1.

Chapter 9: Drugs are More Important than Common Sense

Why so many drugs?

Medications are the number one weapon used by doctors to fight disease. While they are

very effective at combating disease there are often other options. Many diseases need to be managed with medications, but often lifestyle interventions - such as weight loss, exercise, smoking cessation and reducing the amount of alcohol consumed - are overlooked as viable treatment options by doctors.

Prescribing a medicine is an easier solution than spending time teaching the patient about lifestyle changes. Diseases such as diabetes, high blood pressure and high cholesterol are examples of diseases that can be treated with lifestyle interventions.

While lifestyle interventions are great treatment options for many diseases, they require work by both patient and physician. Lifestyle changes are difficult to make and many patients are unsuccessful at incorporating them into their lives. It also takes doctors a lot of time to teach these techniques and many feel that their efforts are fruitless. A doctor may argue, "Why should I spend all that time teaching about a lifestyle change that a person will likely not comply with, when I could prescribe a drug that would do the same thing and take up less of my time?"

Patients are often started on medicines and never taken off. One common reason patients are not taken off medications – in an age when more than one doctor cares of any given patient - is the doctor is not sure why the medication was started and fears that taking the patient off the medication may be a detriment to his or her health. It has been said by more than one doctor, "If I knew why the patient was put on this drug, I would consider stopping it." In an ideal world the physician would do an extensive investigation to determine the reason that the patient was initially placed on the drug, but in our busy health care setting this is rarely done.

In today's health care climate, patients see multiple specialists. While this helps assure that each condition is being treated appropriately, it often leads to a dilemma that health care professionals call polypharmacy. Polypharmacy is a situation where individuals are on multiple medicines that may be duplicate medications or ones that interact with one another.

Generally speaking, the more specialists a patient sees the more medicines they are going to be on. Many doctors feel the need to do something about any complaints a patient has. At times this is justified, but every complaint does not need a medicine. What the doctor does about the complaint varies but it often involves prescribing a medicine.

Going to the hospital is another way people get more drugs added to their regime. Hospitalization is a time when a patient is sick and certain medications are needed to prevent a condition from worsening or to treat an acute problem. Patients typically come out of the hospital on more medications than when they went in.

An example of this is when a patient is in the hospital they are often placed on something to protect his or her stomach from ulcers. These medications are often not stopped and are carried on to the discharge papers resulting in another medication to the medicine list. These drugs are often not needed on a long-term basis and could safely be stopped – but are often not stopped.

Drug companies are partly responsible for the over prescribing of medicine. Drug companies spend billions of dollars a year advertising. Marketing directly to physicians and direct to consumer advertising raises awareness of drugs as treatment options for many diseases and conditions.

The drug companies educate physicians. Many continuing education conferences and programs are sponsored by drug companies that do a great job at promoting treatment of a specific disease or symptom with a specific medication. Conferences sponsored by drug companies are very popular because they often provide gifts and food for attendees. There are few continuing education conferences that focus on lifestyle changes to heal the body. Who would sponsor such a conference?

Direct to consumer advertising raises public awareness about the effectiveness of medication. When the consumer understands a drug can treat a certain condition, he or she is likely to ask the doctor for a specific drug to treat a disease. The American public feels that treating a condition that they have with a medication is a simple way to get a cure. If there were more public service announcements about how exercise can control cholesterol, blood pressure and diabetes, would more patients be asking the doctor about these as treatment options for his or her disease? But, who would pay for these public service announcements?

Drugs cause people to get sick, especially the older population. Adverse drug reactions occur many times every day. It is estimated that 1.5 million people are admitted to the hospital and 100,000 deaths occur every year because of adverse drug reactions (2).

Age related changes increase the risk for drug related complications. The kidneys – which are responsible for excreting many medications - function less effectively as one ages. Doses that could be handled in a twenty-year-old will not be excreted in an older individual and will build up the body, leading to increased risk of toxicity.

The liver, which also breaks down many drugs, tends to lose function with age. In addition to the age changes, many disease processes are more common in the older population that decrease organ function and lead to a more difficult time metabolizing medicines.

Normal age related changes increase the risk for adverse drug reaction. Total body water is

decreased in the older population. Diuretics are common drugs used to treat high blood pressure and combining a diuretic – which depletes the body of water - with the natural decrease in total body water, increases the risk of dehydration.

The amount of protein in the blood decreases as one ages. One of protein's jobs is to binds certain medications - most notably seizure medicines and blood thinners. Less protein in the blood translates to higher drug levels at any given dose. This increases the risk of toxicity.

Also, older individuals have a decreased ability to absorb medicine due to changes in the gastrointestinal tract resulting in the drug not being absorbed as well into the blood.

Medication Errors

The causes of medication errors are varied and vary by health care setting. In the outpatient setting a common error is the pharmacist filling the wrong prescription due to inability to read the physician's handwriting. Patients not understanding the instructions to take the medicine are another common cause of error. Communication with the doctor and pharmacist can reduce errors in the outpatient setting.

As the patient, it is essential that your doctor communicates with you about the drug he or she is prescribing. A critical step in reducing errors is utilizing the doctor visit forms outlined in chapter 4 and displayed in appendix B. Take notes on any new drug prescribed by the doctor as outlined on the doctor visit form. In addition to the doctor visit forms, use the questions outlined at the end of this chapter (Table 6-1) when you are prescribed a new drug. If you have good notes on what the doctor prescribed, you will be able to question the pharmacy if any inconsistency is noted.

In the hospital errors often result from lack of attention rather than lack of knowledge. The nursing staff is often overworked and make errors in administering medicine. Another common cause of hospital errors is not getting an accurate history from the patient. The doctor performing the initial work-up on the patient may not get an accurate list of the medications the patient takes. This results in the patient not getting medications that are needed.

Utilizing the hospital form outlined in chapter five and displayed in appendix B will reduce the risk of getting an incorrect medication in the hospital. Keeping your personal hospital chart next to your bed assures you receive only medications that are meant for you. In addition, when entering a hospital, presenting an accurate medical history and list of medications you are currently on to the attending doctor reduces the risk of drug errors. A system to organize and communicate your medical history including your medications is provided in chapter 11.

Side Effects

Not all adverse drug reactions are a result of error. Medicines are dangerous substances and great care must be taken when they are prescribed. All medicines have side effects and many side effects are known and considered normal. Some medicines have more side effects than others. Some side effects get better when the patient gets used to the drug while others persist indefinitely. Some side effects are easy to spot such as diarrhea and others are subtler, such as fatigue.

Side effects vary by drug and can range from a mild inconvenience to life threatening. Common side effects include: fatigue, diarrhea, constipation, nausea, vomiting, decreased appetite, memory impairment and kidney dysfunction. Life threatening side effects include: abnormal heart rhythms and lung damage. Some medications have more side effects than others and it is important to discuss side effects with your doctor when you are being placed on a new drug.

Reporting the side effects is an important aspect to drug therapy. When started on a new drug, you will typically have a follow up appointment with your doctor. This is the time to discuss and report side effects. Some side effects are expected and if present will not change the course of treatment. Other side effects may be life threatening or so severe that the risk of therapy is not worth the benefit of treatment.

Knowing about the new drug is a key feature to health care responsibility. Understanding why the drug is taken, its side effects, and follow up needed for the drug is essential. Always ask the questions listed at the end of this chapter (Table 6-2) when you are prescribed a new drug.

Drug Interactions

Drug interactions are negative effects resulting from the mixing of two or more medications. Drugs have variable effects on other drugs - they can intensify or blunt the desired effect of another medication.

For example, patients on a blood thinner called coumadin need to have tight control of the blood level requiring frequent laboratory evaluation to assure the drug is therapeutic. The addition of an antibiotic has the potential to increase or decrease the amount of drug in the blood placing the patient at elevated risk for bleeding complications if levels become too high or risk of clots if levels are too low. Individual variation is common with drug interactions. Certain medications will interact more in one individual than another individual with variation being explained by individual body chemistry.

Older adults are on more medicines and therefore have an increased risk of drug interactions. In the older individual, who are on multiple medications, adverse reactions can occur due to drug interactions. Medical science lacks extensive research on drug interactions, especially when patients are on more than two or three drugs. The addition of medication to any patient has the potential for negative outcomes. The interaction between the other drugs, disease states and the individual's body chemistry is variable.

Drug interactions are a complex topic - entire books have been written about the topic. Whenever you are started on a new drug, talk to the doctor and pharmacist about any potential interactions. The pharmacist may have a better idea of the interactions present because they have computer programs available to help sort out complicated drug regimes.

Complications

Complications are adverse events from drugs that cannot be classified as a side effect, interaction or error. A bacterial infection causing severe diarrhea secondary to antibiotic therapy, called *Clostridium difficile* (also known as C. diff.), is one common complication. *Clostridium difficile* is a bacterium that invades the gastrointestinal tract causing severe diarrhea.

Another complication is addiction to drugs with certain drugs being more addictive than others such as sedatives and painkillers. Drugs are not benign substances - health care providers need licenses to prescribe them for good reason. With the many potential errors, side effects, drug interactions and complications extreme caution must be used when using medication.

Drug issues

New Drugs: They must be better

Drug company representatives do a great job marketing new drugs. I am amazed at how frequently I see physicians put patients on drugs that have just come to the market. These drugs are often prescribed when there is a similar drug that has many years of proven safety and efficacy behind it. It is understandable if a patient has a life threatening illness and the new drug is the only option, but this is typically not the case.

Be cautious about the use of new drugs, there are many risks with these new medicines. When a new drug is approved many things are not known about it, such as all side effects and adverse reactions. Question your doctor carefully if he or she prescribes a drug that has been recently approved. Ask why he or she is prescribing the new drug as opposed to an older, better-studied drug. Your doctor may have good reason to prescribe the new drug, it is just important for him or her to consider why it is being prescribed.

An estimated 2.5 billion dollars were spent on direct to consumer advertising for medicines in 2000 (3). Much of the money that is spent is on the newer medicines. Between the years of 1975 and 1999 approximately 10% of the newly approved drugs were pulled off the market or a serious warning was placed on them after they received Food and Drug Administration (FDA) approval (4). FDA approval for a drug does not guarantee that it is safe. Many of the problems with new drugs only surface after FDA approval when a larger number of patients are placed on the drug.

Table 6-1 Questions to ask about new drugs

- What evidence is there that this drug is better than a more established drug?
- Has evidence been published in a reputable journal?
- Was information you got on this drug from a peer-reviewed journal or from a drug rep?
- Do you have any financial ties to the company that makes this drug?
- Are you paid to put me on this drug? For example in a drug study.
- Is this drug better because it is given at a higher dose? Would a cheaper drug be as effective at a higher dose?

Compliance

Many older Americans have difficulty getting medicine, whether this be getting to the store to pick them up or unable to physically take the medicine due to visual impairment or a dexterity problem.

Medicines are expensive. Some older patients have to choose between taking medicine and eating. Due to the high cost of medicines and the multiple medicines older individuals are on, it is often not possible to afford all of the medicines. It is not unusual for a patient to get a prescription for a new drug at the doctor's office and be unable to fill the prescription. This can result in progression of disease resulting in the doctor prescribing another medicine that the patient cannot afford.

If you are unable to take the medicine for any reason – tell your doctor. Other solutions often exist, but they cannot be implemented if the doctor thinks you are taking the drug.

Over the counter medicines

Over the counter (OTC) medicines are generally safe when taken by healthy adults. These drugs are not without risk, especially in the older adult with other health problems. Some OTC medicines interact with prescription medicines. Yet, another good reason to get know your pharmacist. Your pharmacist, if they are familiar with your medial history, can help guide you to

safe and effective OTC medicines.

Some OTC drugs need to be used with special caution in patients with certain conditions. Acetaminophen (Tylenol) needs to be used in moderation in patients who drink alcohol on a regular basis or have liver disease. The combination of acetaminophen and alcohol can lead to liver damage.

Another potential complication includes combining ibuprofen (Advil, Motrin) or Naproxen (Aleve) with alcohol due to the potential for a stomach bleed. Patients who are on warfarin (coumadin) need to use caution when taking any OTC. Medicines have a high propensity for interacting with the warfarin causing either levels going to high and putting you at risk for bleeding or lowering levels and putting the patient at risk for clotting.

Many remedies for colds have the potential for side effects. Most people do not think twice about taking a cold remedy but they can be very dangerous. Two popular ingredients in cold remedies - decongestions, which help to reduce nasal congestion and antihistamines, which can decrease sneezing, dry up watery eyes or runny nose – have potentially serious side effects. Decongestants have the potential to increase blood pressure. Antihistamines have the potential to cause increased confusion, constipation, retention of urine and dry mouth.

Never take over the exceeded recommended dose of over the counter medicine.

Chapter 10: Patients do not Take Responsibility

Chapter 11: What can you do?

The goal of this book is to provide a framework for partnering with the health care system to manage your health. Doctors do not have all of the answers; they require the help of each of their patients to manage health and disease. The information that you provide your doctor assures great health care.

How to get the Best Health Care in the World

Despite its many problems, many experts would argue that the United States has the best health care system in the world. Many foreign diplomats come to the United States to receive health care and top-notch treatment. If you know how to take advantage of it, America has the best health care in the world. To get great health care you need to be educated, organized and able to communicate.

Being educated does not mean that you need to have a medical degree or even a high school diploma; it means that you know how to get and transmit critical information. This book will equip you with the knowledge and the tools to get great health care.

Having a system to organize and communicate your health information will significantly improve health care. The book outlines a system to organize your information including your past medical history and any current problems you are having. Having this information improves the relationship with your doctor and having a good relationship with the physician who serves as your primary care provider is an essential step to getting optimal health care.

Individuals who are questioning tend to get better health care. Diseases are not universal. Each individual must understand how his or her disease affects him or her personally. It is not good enough to get a book about a chronic disease that you have and feel you have a firm understanding of how that disease affects you. This is a good start, but it is imperative you understand how the disease affects you. Questions outlined through out the book are questions you should understand about your personal health. If you are unable to answer the questions; talk to your doctor.

Despite the many problems with our health care system we are unlikely to see any major changes in the system. Changes that affect the bottom line of insurance companies, pharmaceutical companies, large employers and some elements of the medical establishment are not likely to occur. These groups have many powerful lobbyist groups in Washington and the chance of seeing major reform is unlikely.

The current capitalistic health care system focuses on profit instead of patient care. This does not mean that you cannot receive great health care in the current system. It does mean that you will have to do more than have a good doctor. You need to take responsibility for your health care. Health care responsibility includes understanding your health and disease states, organizing your health information and communicating it with the system.

Health care responsibility is a process that starts with understanding your medical history and ends with receiving great health care. This process involves organizing your past medical history and understanding your future health care needs. It is an ongoing process requiring an initial investment of time and energy to complete the personal health record. After the record is set up, it is updated at each health care encounter or with any change in care.

This system allows you to become an expert in your personal health care. Maintaining your

record permits easy transmission of information to health care providers and assures you are in line with national recommendations of health care.

Communication is a vital step to good health care. Face to face contact time with health care provider is limited and each person needs to know how to maximize this time. Good communication is partially accomplished by being organized and helps overcome the shortcomings of the modern health care system. The personal health record system outlined here improves communication with the health care system.

The doctor visit is a business transaction. Use this very valuable time wisely and transmit essential information. This does not mean that you should be unfriendly but use the time wisely. Taking an active role in your health care; maintaining a personal health care record provides a sense of power and assures you are getting appropriate care.

Medical Record

Medical records are complex and contain multiple pieces of personal and medical information. It is vital that every health care provider has full knowledge of your medical history. Older patients typically have a long medical history and being able to transmit this information to the health care system bestows a distinct advantage in getting the best health care.

The personal health record, which is similar to a medical chart that a physician or health care system would keep on you, guarantees you are receiving the best health care possible. With the fragmentation of the health care system it is important to have all health care information in one spot. Maintaining your health record allows you stay organized and transmit accurate information to your health care providers.

All of your physicians and every health care setting, such as hospitals, nursing homes and surgical clinics, keep a copy of your medical record. Your medical record contains items that pertain to your health such as doctor's notes, lab work, surgical reports, and radiological exams. Your personal health record contains all things contained in a medical record – but more. The personal health record assures that all of your health record is stored in one place. No more worrying about if your primary care doctor did not get a copy of a lab test or diagnostic procedure – you will have a copy that you can share.

Medical records are often incomplete. If you receive services from another health care provider or health care system, this information is likely not known to your doctor. Communication within the health care system is not optimal; each individual must take that responsibility upon himself or herself.

Table 11-1: The importance of maintaining a personal health care record

1. Provides a concise and complete way to organize complex medical histories
2. Improves communication of health information
3. Increases time with health care providers as less time is required for doctors to extract information
4. Secures more effective and efficient care
5. Allows patients to be partners in his or her health care
6. Cuts down on unnecessary testing because tests results will be available
7. Reduces medical errors