LOUISIANA HOSPITAL ASSOCIATION
MALPRACTICE AND GENERAL LIABILITY TRUST

A CLOSER LOOK AT MEDICINE SEPTEMBER | 2017

eNSIGHTS

Family doctors in demand

For the 11th consecutive year, family doctors top the list of the most-highly recruited physicians in the U.S., followed by psychiatrists, according to an update from Merritt Hawkins.

"Emerging delivery models that reward quality and population health are driving demand for family doctors," says senior vice president Travis Singleton. "Consumer preference for urgent care centers, retail clinics, community health centers, telehealth, and other modes of convenient care, is another key factor accelerating the recruitment of family doctors," he adds.

The report shows that demand is exerting upward pressure on salaries. The average starting salary for family physicians is $231,000, compared to $198,000 in 2015. The average starting salary for psychiatrists, who also are in great demand, is $263,000, up from $226,000 two years ago.

The 2017 report indicates the firm conducted more searches for psychiatrists in the past year than it had in any previous 12 months in its 30-year history. A study in the May 2016 issue of **Health Affairs** reported that for the first time the U.S. is spending more on treating mental health disorders than any other condition, including heart disease, trauma, and cancer.

Earlier this year, the National Council on Behavioral Health cautioned that the nation does not have enough psychiatrists and, despite growing demand, their numbers declined by 10% between 2003 and 2013. The agency added that sometimes it takes hospital emergency departments as long as 23 hours to place some patients who need mental health services.

"Psychiatrists, particularly those willing to work in inpatient settings, are becoming next to impossible to find, and mental health is increasingly handled by other types of clinicians," reports Merritt Hawkins.

Longer waits to see a physician

New patients seeking an appointment are enduring much longer waits even in urban areas with a plentiful supply of physicians, according to a survey by Merritt Hawkins, a national healthcare firm specializing in recruiting physicians.

For large markets – such as Boston, Atlanta, Denver, and Los Angeles – the average wait time to see a family medicine physician is 29 days (up 50% from 2014), and ranges from a high of 109 days in Boston to a low of eight days in Minneapolis.

In mid-sized markets – such as Albany, Savannah, Billings, and Yakima, Washington – the average wait time to see a family medicine physician is 56.3 days and ranges from a high of 122 days in Albany, New York to a low of seven days in Billings, Montana.

The wait times may be even longer for patients covered by Medicare and Medicaid as the survey revealed only 85% of physicians in large markets accept Medicare and only 53% accept Medicaid. In mid-sized markets, 81% of physicians accept Medicare and 60% accept Medicaid.

Merritt Hawkins conducted similar surveys in 2004, 2009, and 2014. The latest survey was conducted between January 9 and February 13 and included family medicine, cardiology, dermatology, obstetrics-gynecology, and orthopedic surgery.

"Physician appointment wait times are the longest they have been since we began conducting the survey. Growing physician appointment wait times are a significant indicator that the nation is experiencing a shortage of physicians," says president Mark Smith.

The firm noted that in its experience in evaluating physician practices, a physician generally is considered to be busy if the practice is booked for new patient appointments two weeks or more in advance. In such cases, the recruitment of a new physician partner or associate may be warranted. It also is at this point that patients in the community often begin to voice concerns about physician accessibility.

Merritt Hawkins says it is likely that longer wait times are due to the expansion in the numbers of insured under the Affordable Care Act, which added nearly 20 million people. Another reason may be the rapid rise in the numbers of the elderly, who are three times as likely to see a physician as younger adults, and account for a higher number of procedures and tests. The firm notes that every day more than 10,000 Americans turn age 65.

According to the Association of American Medical Colleges, there currently is a deficit of 21,800 physicians in the U.S., which is projected to rise to 65,500 in 2020 and perhaps to 90,400 by 2025.

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A view from afar

Increased use of antidepressants

Antidepressant use in the U.S. increased nearly 65% over a 15-year time frame, from 7.7% in 1999-2002 to 12.7% in 2011-2014, according to a report from the National Center for Health Statistics.

During 2011-2014, about one in eight Americans aged 12 and older reported taking antidepressants in the previous month. Antidepressant use increased with age and was twice as common among females as males. Non-Hispanic white persons were more likely to take antidepressants than non-Hispanic black, Hispanic, and non-Hispanic Asian persons.

The rate of increase was similar among males and females. At every time point, females were about twice as likely as males to report antidepressant use in the past month, the center said.

Antidepressants are one of the three most commonly used therapeutic drug classes in the United States. While most antidepressants are taken to treat depression, antidepressants can also be taken to treat other conditions, like anxiety disorders.

Long-term antidepressant use was common. One-fourth of all people who had taken antidepressants in the past month reported having taken them for 10 years or more.

The most-recent report from the National Center for Health Statistics includes children aged 12 and older. A study reported last year in **JAMA Internal Medicine** found one in six adults in the U.S. had taken a psychiatric drug at least once during 2013. This included drugs classified as antidepressants, anxiolytics, sedatives, hypnotics, and antipsychotics.

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On the horizon

Computer diagnoses skin cancer

Computer scientists at Stanford University have programmed a computer to detect and diagnose different types of skin cancer. In lab testing, described in the journal **Nature**, the computer performed as well as the board-certified dermatologists it was tested against.

During testing, the researchers used high-quality, biopsy-confirmed images that represented the most common and deadliest skin cancers. The 21 dermatologists in the experiment were asked whether, based on each image, they would proceed with biopsy or treatment or would reassure the patient.

When it came to melanomas, the computer program, developed in collaboration with dermatologists, was able to classify 96% of malignant growths and 90% of benign lesions, compared to the dermatologists who identified 95% of malignancies and 76% of benign lesions.

The computer scientists say the learning algorithm they created – a type of artificial intelligence – enables the computer to learn from data it receives. "Instead of writing into computer code exactly what to look for, you let the algorithm figure it out," is how one of the scientists explained it.

Separately, IBM reports Watson, its famous computer, is using advanced analytics to make valuable contributions in oncology by suggesting tailored treatment plans for patients based on their unique medical records, an understanding of the latest advances, and a knowledge of all ongoing clinical trials.

IBM says Watson can keep up with medical advances and virtually all of the scientific literature because it can read 200 million pages of text in three seconds.

PET scans alter dementia diagnosis

Many patients diagnosed with mild cognitive impairment or dementia and who are taking medication for Alzheimer's may not have the disease, according to a major study underway to see how PET scans could improve diagnosis and treatment of Alzheimer's.

The **Washington Post** reports the findings come from a four-year study that is testing nearly 18,000 Medicare beneficiaries with mild cognitive impairment (MCI) or dementia to see if their brains contain the amyloid plaques that are one of the two hallmarks of the disease.

"So far, the results have been dramatic. Among 4,000 people tested, researchers from the Memory and Aging Center at the University of California at San Francisco found that just 54.3% of MCI patients and 70.5% of dementia patients had the plaques," the newspaper reported.

More than 400 physicians enrolled their patients in the study. After seeing the PET imaging results, the physicians changed their care plans for two-thirds of the patients, the **Post** added.

PET scans cost $3,000 to $4,000 and are typically not covered by insurance. But the Centers for Medicare & Medicaid Services agreed to fund the bulk of the $100 million study now underway by reimbursing participants for their PET scans.

James Hendrix, a spokesman for the Alzheimer's Association, told the newspaper the findings could have broad implications. "We thought we would be able to see about a 30 percent change, but we're getting a 66 percent change, so it's huge. We see high percentages of people who are on a drug and didn't need to be on those drugs," he said.

New thinking on antibiotic use

Antibiotics are among the most-widely prescribed drugs in the U.S. and, surprisingly, nearly 50% of them are prescribed inappropriately, according to the Centers for Disease Control and Prevention.

Each year nearly 266 million prescriptions for antibiotics are dispensed to outpatients in community pharmacies. CDC reports that a large number should not have been prescribed at all, others should have been prescribed at higher or lower doses, and some were prescribed for too long or not long enough.

A recent commentary from infectious disease specialists in the UK makes an even more startling point about antibiotic use – there is no scientific evidence behind the age-old advice that a patient must take the entire prescribed course. Indeed, the researchers suggest, it is not unreasonable to advise patients "stop when you feel better."

Writing in the July 26, 2017 issue of **BMJ** (formerly the British Medical Journal), Martin Llewelyn and colleagues say since there is little evidence that failing to complete a prescribed antibiotic course contributes to antibiotic resistance, it's time for policy makers and public health authorities to drop this message.

Currently, the World Health Organization and physicians and public health authorities in nearly every country emphasize that patients who fail to complete a prescribed course put themselves and others at risk of antibiotic resistance.

Actually, the researchers say, the opposite is true, as taking antibiotics for longer than necessary increases the risk of resistance. On the other hand, they add, there is little evidence that it would be harmful to patients if antibiotics were prescribed for shorter durations than is now the practice.

"We...encourage policy makers, educators, and doctors to stop advocating 'complete the course' when communicating with the public. Further, they should publicly and actively state that this was not evidence-based and is incorrect," they write.

The **BMJ** article created a worldwide sensation in the popular media as it seems to stand conventional wisdom on its head. Surprisingly, public health authorities agree there are no hard and fast rules. Lauri Hicks, director of the Office of Antibiotic Stewardship at the CDC, says "I recommend that if a patient is feeling better while taking a course of antibiotics, that the patient or the patient's family should consult a physician to see if those antibiotics can be safely stopped."

She cautions that patients should not stop taking their prescribed antibiotics on their own. "I think it really needs to be a decision made with input from the provider. In certain circumstances taking the full course is important, and it may not be as important for some other, milder infections," she told **Scientific American**.

Lance Price, a microbiologist and director of the Antibiotic Resistance Action Center at George Washington University, told the magazine it makes sense to stop taking an antibiotic once you are feeling better. "My thought is that this is a radical stance – although in some ways correct. This [commentary] is a really good thought piece," he said. But, he added, it would be irresponsible for public health officials to tell patients they can decide on their own when to stop taking the antibiotic.

Helen Boucher, a professor of medicine and infectious diseases at Tufts Medical Center and a spokesperson for Infectious Diseases Society of America (IDSA), says "I think the spirit of this paper is very much in line with what IDSA advocates for. As part of the strategy to combat the antibiotic resistance crisis, we should think about strategies to use less drugs and use drugs for shorter duration," she told the magazine.

However, she added, some studies do indicate shorter antibiotic courses would leave certain patients vulnerable to a resurgence of infection or, in some cases, lead to antibiotic-resistant organisms. By and large, infectious disease experts weighing in on the recent commentary agree there is room for fresh thinking about antibiotics but conclude the problem is too complex to be expressed in a simple message.

Medications

More errors by consumers

Serious errors by consumers taking medications at home doubled between 2000 and 2012, according to a study reported in **Toxicology**.

Researchers reviewed reports to the National Poison Database System data from 2000 through 2012. "The overall average rate of these medication errors was 1.73 per 100,000 population, and there was a 100.0% rate increase during the 13-year study period. Medication-error frequency and rates increased for all age groups except children younger than 6 years of age," they reported.

Common errors included incorrect dose, taking or administering the wrong medication, and taking the medication twice. The drug category frequently associated with serious outcomes was cardiovascular drugs (20.6% – primarily beta blockers, calcium antagonists, and clonidine).

Also problematic were analgesics (12.0% – most often opioids and acetaminophen) and hormones/hormone antagonists (11.0% – in particular, drugs used to manage diabetes).

The Institute for Safe Medication Practices advises patients to be alert to the types of errors that can occur. "Find out what drug you're taking and what it's for. Rather than simply letting the doctor write you a prescription and send you on your way, be sure to ask the name of the drug. Also ask the doctor to put the purpose of the prescription on the order," the group says.

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Mayo Clinic reveals open secret

Mayo Clinic's CEO has told employees that other health conditions being equal, Mayo's new policy is to give preference to patients with private insurance over those with Medicare or Medicaid coverage.

The Minneapolis **Star Tribune** obtained a transcript of the remarks made by Dr. John Noseworthy and Mayo has confirmed the transcript is authentic. Dr. Noseworthy told employees that when two patients are referred with equivalent conditions, the health system should "prioritize" those with private insurance.

"We're asking...if the patient has commercial insurance, or they're Medicaid or Medicare patients and they're equal, that we prioritize the commercial insured patients enough so...we can be financially strong at the end of the year to continue to advance our mission," Dr. Noseworthy said in a videotaped speech to staff late last year.

He made it clear Mayo will always take patients, regardless of payer source, when it has medical expertise they can't find elsewhere. Mayo spokesman Karl Oestreich told the newspaper the health system remains committed to publicly funded patients – who make up half the health system's business – even with the new policy.

"We can provide the care they require for complex medical issues. However, we need to balance requests from these patients with their specific needs – if it's necessary for them to come to Mayo – as well as the needs of commercial paying patients," he said.

In the politically correct world of healthcare and public policy, "it is rare to hear a hospital leader espouse any strategy that promotes access for privately insured patients at the expense of publicly funded patients," the newspaper noted.

Mat Keller, who monitors healthcare policy and hospital finances for the Minnesota Nurses Association, told the publication "the most interesting thing isn't that it's happening; it's that a high-level executive actually said it out loud."

In his remarks to Mayo employees, Dr. Noseworthy said a recent 3.7% surge in Medicaid patients was a tipping point for the health system. "If we don't grow the commercially insured patients, we won't have income at the end of the year to pay our staff, pay the pensions, and so on. So we're looking for a really mild or modest change of a couple percentage points to shift that balance," he said.

According to the **Star Tribune**, Mayo reported a sharp increase in the amount of unreimbursed costs related to Medicaid patients, from $321 million in 2012 to $548 million in 2016. The figures include its campuses in Arizona and Florida. Mayo nonetheless remained profitable in 2016, with income of $475 million.

The Mayo policy would not affect emergency room care, because federal law requires hospitals to treat patients who show up with urgent needs. Nor do Mayo officials expect it to be applied often, because it would be rare for equivalent patients with different insurance to show up at the same time and force a choice, the newspaper said.

But Allan Baumgarten, a Twin Cities health analyst, envisioned scenarios when it could affect Mayo's scheduling of patients. Caseworkers already take insurance information when patients call for appointments, he noted.

Faster door-to-balloon times

More than 93% of heart attack patients are receiving stents within 90 minutes after arriving at the hospital, and the median time to stenting is only 59 minutes, according to a report from the American College of Cardiology.

The widespread improvement, experienced across the country and across different types of hospitals, amounts to a "transformation in care," writes Dr. Harlan Krumholz, a cardiologist at Yale University. In 2005, the median time to stenting was 96 minutes.

He attributes the gains to a major campaign launched in 2006 by the American College of Cardiology. Called the Door-to-Balloon Alliance for Quality, the program involved more than 1,000 hospitals and 20 organizations. It was the first time the entire cardiovascular community came together and focused as a team on improving care.

Dr. Krumholz notes that critical to success is the interdisciplinary team which, for the first time, extends beyond the walls of the hospital to include emergency medical services. Also important are the pre-hospital electrocardiograms by EMS and direct transfer of patients to the cath lab as soon as they reach the hospital.