President's Message .... *Fred Rubin, MD*

Several random articles have crossed my desk recently that remind me of the ancient Chinese curse "may you live in interesting times". Our times may be getting a bit too interesting! Here are some specifics:

First, our healthcare system provides extraordinarily poor economic value. We spend over 17% of our GDP on health, which is double what most nations spend, yet our outcomes are mediocre. Internationally, the U. S. ranks only 49th in life expectancy and 42nd in infant mortality. On the World Health Organization (WHO) index of overall health, we rank about 40th. We are now spending over $2 trillion annually to produce these poor results.

Despite these expenditures, over 50 million of us have no medical insurance. Being uninsured means that people do not receive preventive care or appropriate management of chronic conditions. It has been estimated that lack of insurance leads to 24,000 unnecessary deaths annually in this country. Even people with insurance who have chronic illnesses can spend all their resources on health care due to gaps in coverage. One recent report showed that 20% of all personal bankruptcies were caused by medical expenses so far in 2011.

Second, an unfortunate hallmark of our system is variability. The classic example is variation in services and outcomes based upon race. For example, African-Americans have worse health outcomes and life expectancies than whites. Another type of variability is geographic. The death rates of strokes and myocardial infarctions are higher in rural hospitals than in urban hospitals. Access to specialists is less in rural areas. Residents of New Jersey outlive residents of South Dakota by years. Medicare spending per beneficiary varies by a third from one region of the country to another. Drug costs per beneficiary vary by up to 60% between regions.

In Pittsburgh, patients with chronic diseases are hospitalized 50% more than the national average. This is the highest rate in the nation among large urban regions. Medicare patients here undergo surgery 10% more than elsewhere, including 23% more heart valve replacements, 14% more coronary artery bypasses, and 8% more laminectomies. Our costs are the highest in the country, yet our mortality rate is the 11th worst. 23% of our Medicare hospital discharges are readmitted within 30 days. Is something wrong with this picture?

The most important type of variability is failure to translate knowledge from research into consistent clinical practice. This represents under-utilization, versus the examples of over-utilization above. Multiple studies have shown that we follow evidence-based guidelines only about half the time. Examples include failure to prescribe aspirin after an MI, failure to prescribe a beta blocker after an MI, failure to monitor lipids in a diabetic, and failure to prescribe a statin after an ischemic stroke.

Third, although the rates of malpractice suits in Pennsylvania have decreased in recent years, national rates are still staggering. A recent article in the New England Journal analyzed data from 1991 through 2005 for approximately 41,000 physicians nationwide. Each year during the study period, 7.4% of all physicians were sued. The proportion of physicians facing a claim each year

ranged from 19% in neurosurgery to 2.6% in psychiatry. Interestingly, emergency medicine physicians were sued at about the same rate as internists, at 7.5%, while family physicians were sued at only 5.2%. It was estimated that by the age of 65 years, 75% of physicians in low-risk specialties will have been sued, while the rate for high-risk specialties is 99%!

Fourth, after 8 years of ACGME-mandated caps on resident work hours and work volume, did patient care get any better? According to a recent systematic review in the Journal of General Internal Medicine, the answer remains unclear. Overall mortality did decrease by 10%, but this may reflect temporal trends not related to resident work hours. Rates of hospital complications have been variable. Adequacy of operative experience for surgery residents remains uncertain. It does seem that the rate of resident "burnout" has decreased, and residents now have more personal and family time.

Finally, what are we to make of the conflict between UPMC and Highmark? These are large corporations positioning themselves for the future, when reimbursements are likely to be less than they are today. Going forward, one can imagine a region with two competing integrated delivery and financial systems (called an IDFS), each employing a large number of physicians, and each competing for patients. This is actually the way healthcare is already delivered in many other parts of the country, but it will be quite disruptive here as doctors and patients must choose which way to align themselves over the next year or two.

In these "interesting times", what should an individual health professional do? I have two suggestions. At the macro level, we should remember the guidelines proposed by the Institute of Medicine 10 years ago in their watershed report *Crossing the Quality Chasm*. The IOM aims for an ideal health system include:

- Safe (don't cause harm)
- Effective (evidence-based, appropriate)
- Patient-centered (incorporates patient values and preferences)
- Timely (minimal waiting)
- Efficient (reduce waste)
- Equitable (uniform high quality regardless of geography, socioeconomic status, race, sex)

We still have a long way to go.

At the micro level, we must keep our patients at the center of activity, delivering the best care we can, while respecting their values and cultures. Although there is much around us that we cannot control, we can always control how well we treat our patients.

Best wishes,

Fred Rubin, MD

Dr. Rubin's article was also published in the October 2011 *Bulletin* of the Allegheny County Medical Society.