North Coast Physician

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The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication. hdncms@sbcglobal.net

Cover Photo
"HIPPO 2008"
Stephen Kamelgarn, M.D.

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Medical Reversal

Lee Leer, M.D.

When I'm not busy re-reading all of John Gierach's wonderful essays on fly fishing and life, I've lately been reading "Ending Medical Reversal," by Vianyak Prasad and Adam Cifu.

Prasad and Cifu delve into a subject that I've often thought about over the years. Most of us, I'm sure, have heard some version of the axiom that "Fifty percent of what you learn in medical school will be proven to be wrong… we just don't know which fifty percent that is." Prasad and Cifu quote various studies that suggest the true number is closer to 40%. But still.

During my career, I've certainly promulgated an embarrassing number of mis-truths upon my patients. I can still hear myself explaining to post-menopausal women why they needed to be on hormone replacement therapy the rest of their lives ("yes, it's natural to go through menopause, but we didn't evolve to live into our 50's, let alone beyond, so you need those hormones to stay healthy!"). I've also certainly contributed to goodness knows how much excess radiation exposure and unnecessary procedures and untold days of fear by encouraging annual mammograms and annual PSA testing, though in my defense, I got over the whole PSA mania so long ago that now I think I've spent more of my career trying to talk patients out of it than into it. And I still have patients on beta blockers for hypertension treatment, even though we now have clear evidence that beta blockers do not decrease overall mortality in hypertensive patients, even though they do lower blood pressure. I just can't seem to remember to have that discussion all the time during my brief and infrequent visits with patients who are quite satisfied with what they perceive to be very effective treatment of their hypertension.

I spent years advocating niacin for hyperlipidemia, ditto omega-3 fatty acids. Oops. At least, I never got on the glucosamine-chondroitin sulfate bandwagon!

Within the hospital setting, we still, I think, isolate patients who screen positive for MRSA, or who are VRE carriers. Yet, such practices are questionably effective at best, and clearly lead to patients having even less contact with physicians, nurses, other caregivers, and probably even with family members. So, for the sake of a logical, but unproven theory, we emotionally and physically isolate sick people at the time they most need human contact.

When the Humboldt Diabetes Project first got off the ground, we were "graded" on meeting certain goals: one was to get systolic blood pressure below 130 mm Hg, another was to have hemoglobin A1c levels below 7%. We now know these were both misguided, yet I know in our community, at least, there is still an overwhelming urge to get that A1c level below 7% in our type II diabetics… even though evidence would suggest we're increasing mortality by doing so. And again, re-educating patients who have had "lower is better" hounded into them for decades is time consuming and difficult. And requires a particular ability to tolerate the taste of crow.

Shortly after completing residency, I recall having an epiphany about Pap smears. Why, I wondered, was I doing them every year on women who had had a total hysterectomy? Why indeed, had this never occurred to me before, and why had none of my gynecology attendings over the years ever discussed this!? I recall asking a very bright, quite experienced colleague what we should do in these situations. It was clear from his reaction that he'd never considered this either, because he looked baffled, and said he'd have to think about it. A few days later he got back to me. He'd thought about it and decided that we probably should not do Pap smears in such women. Fast forward to Humboldt County in the mid-1990's. There was a meeting with various public health professionals, as well as physicians, NP's and PA's. When someone wisely suggested we not devote resources to ensuring that women without cervices still get Pap smears, this provoked a spectacular amount of visceral anger and outrage among many of the providers present. One related a story of having diagnosed vaginal carcinoma with a vaginal cuff Pap smear, and was just not to be reasoned with. We so love our anecdotes and our myths. And so many of us practitioners of our applied science are so NOT trained in scientific thought… or even in basic critical thinking.

So what to do? Well, unlike much of what we talk about in these pages (EMR's, insurance companies, governmental regulation), this is something fully within our control. This is something we can work to fix now, that will have immediate and long-lasting positive outcomes for our patients.

We just need to question ourselves. We need to remind ourselves that a good portion of what we say to patients every day is simply not proven, and much of that unproven stuff is simply wrong. I remind myself every day that (1) I need "to show up," by which I mean "look at the patient and not the computer;" (2) I need to "give a damn," by which I mean "truly care about the patient as a person… and let the patient know I

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"Opinion", Continued From Pg 5

care;" and (3) take time each day to question myself and to be honest with patients and take the time to say "we don't know," when that's truly the case. Too, I resolve to make more regular use of the United States Preventive Services Task Force (USPSTF) recommendations regarding screening and treatments. They are not perfect, but they are the one entity in our health care system that's devoted to overcoming the tyranny of "expert opinion" and advocating critical thinking as a practice style.

Further, we should all take a few minutes to think about the real significance of our recommendations, and share those thoughts with our patients. For example: current guidelines from the American Heart Association would have me advise my low risk female patient with an LDL of 210 that she begin a statin. Indeed, when we plug her data into one of the available risk calculators, her 10 cardiovascular event risk is reduced by 30% if she lowers her LDL to a level we could likely achieve with a statin. Thirty percent is huge, right? Well, in fact, her overall risk pre-treatment is about 3%, and after treatment drops to 2%. So, we'd be treating 100 people for 10 yrs to prevent one cardiovascular event. The real patient in this example chose to live dangerously and forego a statin.

Most often, we really don't know how significant our recommendations are, nor is it easy to find out. Nor are we really trained to think this way. In the spirit of primum non nocere, it behooves us to train ourselves if we really do care to do what's best for our patients. §

REPORT OF CME ACCREDITED ACTIVITIES FOR 2015

Your Humboldt-Del Norte Consortium for Continuing Medical Education has accredited 193 programs - providing over 1,500 hours of AMA PRA CAT 1 CME Credits for our local physicians and medical professionals - through Grand Round Programs, Tumor Boards, Journal Club Meetings, ACLS/PALS, Quality Review and Improvement Activities, Case Conferences, etc.!

The Consortium is a self-supportive Committee of the Humboldt-Del Norte County Medical Society and needs your participation to ensure the survival of the program.

Are you a current member of the Consortium??

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The Consortium Committee is soliciting member physicians willing to serve on the committee (meets quarterly) - help identify and direct planning of local programs that meet the needs of our physicians in Humboldt-Del Norte Counties. PLEASE let us know if you're interested.

Physician representatives are also needed from each of our local hospital medical staffs - to help identify educational GAPS within the hospital.

Are you involved in a committee or organized Regularly Scheduled Session (RSS) that may qualify for accreditation?? Contact our CME Coordinator for more information.

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PHYSICIAN ASSISTANT NEEDED. Busy Arcata primary care practice. Benefits provided. Contact Connie Cartwright, ccartwright@madriverhospital.com (707) 825-4917

PHYSICIAN /APC NEEDED United Indian Health Services, Crescent City & Klamath Clinics. Contact: Katie Terra, MD, *katie.terra@CRIHB.org*

PHYSICIAN /APC NEEDED for established practice. Contact Debbie at (707) 443-4593 *dlee806245@aol.com*

NP/PA NEEDED - Join Redwoods Rural Health Center's team in beautiful Southern Humboldt. 4-day work week, loan repayment & sign-on bonus available. Contact: *Tina Tvedt, ttvedt@rrhc.org.*

PNP WANTED for busy pediatric practice. Salary based on experience; full benefits. Please send cover letter and resume with references to: Emily Dalton at 2800 Harris Street Eureka, CA 95503

NP/PNP NEEDED PART TIME for busy pediatric practice in Fortuna. Resumes may be e-mailed to: kidscare@suddenlinkmail.com or mailed to Redwood Pediatric medical Group, Attn. Vicky Donahue, 3305 Renner Drive, Fortuna, CA 95540.

PHYSICIAN/LEAD APC - Eureka Health Center, Planned Parenthood Northern California. Send CV and Cover letter to careers@ppnorcal.org

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