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# WINTER 2017/2018 - NEWSLETTER

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## The Blood Pressure Guidelines Dilemma

The American College of Cardiology and American Heart Association recently published blood pressure control guidelines that suggest we should be treating blood pressure in 25 year olds the same way we treat it in 79 year olds and older patients. If you have any cardiovascular disease, or a 10% cardiovascular risk assessment over the next few years, they want your systolic blood pressure to be less than 130. They present excellent data explaining that as the blood pressure elevates above 130, the risk of a heart attack, stroke, vascular disease or kidney disease and, ultimately, death increase. No one is arguing these facts.

The American College of Physicians (ACP) along with the American Academy of Family Physicians (AAFP) recognizes this one size fits all in blood pressure control creates many problems. As we age, our arteries become less compliant or elastic. Stiffer arteries are more difficult to assess for blood pressure value. After we have exhausted the lifestyle changes of smoking cessation, weight loss, salt restriction and increased activity to control blood pressure; we are forced to use medications. We try to use low doses of medicines to avoid the adverse effects of the pills that the higher dosages can bring.

These medicines are costly. The more we prescribe the more patients don't take them due to the cost. The more we prescribe, the more patients forget to take multiple pills on multiple schedules of administration. If we get the patients to take the medication we run into the problem of blood pressure precipitously dropping when patients change positions from supine to sitting to standing. If we are lucky, and the patient is well hydrated, then we may only be dealing with a brief dizzy spell. In other cases, we are left treating the consequences of a fall and injury from the fall. The more we try to control your blood pressure to the new levels with medications, the more we consider drug interactions with prescription medicines being prescribed for other health problems seen in older Americans.

At this point, experts from the ACP Policy Board and noted hypertensive experts at the University of Chicago have suggested we follow the more liberal guidelines of the ACP individualizing our care based on the patient's health issues. Personalizing care with individual goals makes sense to me, especially in my chronically ill patients battling blood pressure, weight control, age related orthopedic issues, and age related visual and urological issues plus other problems. My practice strives to allow the time for discussion, questions and evaluation at each visit.

## Level One Stroke Centers and Telemedicine

Our local community hospital is a declared a Level One Stroke Center. This is problematic because it requires a patient with a potential acute stroke to be examined by a doctor and treated within three hours of the onset of symptoms. Patients with a potential acute stroke answer questions and are then either administered "clot busters", or thrombolytic drugs, or excluded because of an unacceptably high risk of bleeding and brain damage. When given in time, the medications are miraculous in resolving acute neurologic symptoms and damage from a stroke.

Hospital administration told staff neurologists they needed to be on Emergency Department call and make themselves physically available, within 45 minutes of stroke patient arrival, to determine if they qualify for the thrombolytic therapy or not.

My colleagues in neurology appropriately declined to agree to take call for strokes in the ED. They could not possibly manage their offices, consults and be on call for the stroke protocol. They wondered why the board certified ER doctors, or for that matter any Board Certified physician working with the protocol questions, couldn't administer the drug if appropriate. As a result, all but two of the 20 neurologists resigned from the hospital staff.

The hospital's response was to hire the Cleveland Clinic's neurology group to question and examine the patients with a robot via telemedicine and make the decision for them. They make the decision and the drug is administered prior to actually calling the patient's primary care physician to inform them of the situation.

I was opposed to this and complained but it's like Don Quixote jousting at windmills. No one listened or cared. I was concerned about a patient being injected with thrombolytics, bleeding into their brain with major neurological damage and then my being informed that I was expected to pick up the pieces and care for the patient.

Last week one of my associates' patients presented with stroke like symptoms. A robot entered the room and questioned his daughter and caregiver and decided he was not a candidate for thrombolytics. I was then called to evaluate and treat him. The family had no idea the doctor talking through the machine was in Ohio.

Recently, a series of articles published in two major medical journals showed the window of opportunity to treat an acute stroke with clot busters was actually 18- 24 hours. Patients don't need to be seen within 45 minutes by a doctor or administered the "clot busters" within three or four hours.

How will this affect designation of hospitals as Level One Stroke Centers? How much money was diverted from patient care and invested in the telemedicine robotic neurology service from Ohio and is it really needed? Will community-based neurologists now be invited back onto the medical staff?

## Emergencies and the Rationale for Our Treatment Algorithm

We are a primary care medical office that tries to deliver personalized attentive care. We define emergencies as chest pain, significant breathing difficulty and loss of consciousness, uncontrolled bleeding or pain, sudden change in mental status and behavior or major trauma. In these situations, my office staff receiving a phone call interrupts me so I can speak with you and determine whether or not to advise you to call 911. We do this because we know with life threatening situations time is of the essence.

Emergency Medical Services at 911 can arrive within 5 minutes. They are all Advanced Cardiac Life Support (ACLS) trained and carry the equipment and medications to provide life sustaining care while you are transported to a hospital Emergency Department that has the staff, medications and equipment to keep you alive while we diagnose the problem and create a plan to rectify it.

The office staff is trained in Basic Cardiac Life Support. We do not have a defibrillator. We do not maintain and store medications to correct low blood pressure - cardiac arrhythmias. We do not have endotracheal tubes to intubate you and breathe for you. In the past, when we tried to maintain these supplies, they became outdated due to infrequent use and were expensive to replace. Since we do very few resuscitations day to day we are not as experienced or efficient as EMS and emergency department personnel are.

I realize the wait for care and institutional care settings are not pleasant. We sacrifice that for the best chance to keep you healthy. Trust me, it is no fun cancelling a scheduled patient to run to the ER and then return already behind. We do it for your comfort and security and safety.

In the recent past patients with chest pain resembling heart disease, trouble breathing and excessive bleeding have refused to call 911 and were upset when we did not bring them into the office. We do this for your health and safety not our convenience. If you would like to discuss this feel free to contact the office.

## Globalization, Corporate Control and Shortages of Medication

One of my online medical information websites carried a letter from the head of the Food and Drug Administration (FDA) trying to explain why there is a shortage of standard intravenous fluids to administer at hospitals and medical clinics in the United States. The author cited an extremely busy influenza season causing patients to use Emergency Departments in record numbers plus a loss of manufacturing capabilities due to damage to a production facility in Puerto Rico during a seasonal hurricane. No more, no less.

Doctors, nurses and patients are expected to believe that there is only one production center for our intravenous fluids nationally located in Puerto Rico. If it is unable to produce and ship product then, health care as we know it, has to change?

If this is in fact the truth, and the only reason for the lack of available IV fluids, what exactly does it have to say about our planning and leadership at the level of the FDA and CDC? Might it, in fact, indict the corporate model of efficiency and productivity? Is there not a Plan B and C for supplies of intravenous fluid if one source cannot supply our needs? If this is in fact the only production source then why wasn't it a post storm FEMA national priority similar to if the NORAD intercontinental ballistic missile system had been damaged due to Hurricane Irma or Maria and we could not monitor international threats?

At the same time we have a shortage of intravenous fluids, we have a shortage of injectable narcotics for pain relief. Morphine and dilaudid are in short supply. My hospital pharmacy committee and chief medical officer are now limiting injectable pain medications to immediate post-surgical cases.

Pain elsewhere in the institution is being treated with the type of oral pain pills we read about which are causing the opioid epidemic and crisis in America. There apparently is no shortage of injectable heroin on the streets of Palm Beach County, Florida. The Mexican cartels have found a way to meet the demand of its customers unlike organized healthcare which seems unable to do so.

I do not know who is responsible for insuring that we have enough materials and medications available to care for our nation. I do know they are doing a very poor job of it and would love to know who is responsible.

## Primary Care Docs Outperform Hospitalists …

A study published recently in JAMA Internal Medicine looked at 650,651 older adults hospitalized in 2013 and all having Medicare as their insurance. The study showed that when patients were cared for by their own outpatient physician they had a slightly better outcome than when the patients were attended to by full time hospital based specialists (aka "hospitalists") who had not previously known them.

As an internal medicine physician who maintains hospital privileges, as well as caring for patients in an office setting, this study supports the type of medicine I have been practicing for the last 38 years. However, I am not naïve enough to believe it entirely. Why?

In recent months similar studies have touted the benefit of female physicians over their male counterparts, younger physicians over older physicians and even foreign trained physicians over those trained in the USA. Based on these studies you may conclude you should find, and be treated by, a young female outpatient physician who trained in a foreign country. While this study showed the success of the outpatient primary care physician, hospitalists can counter by producing their own studies showing the benefit of using a hospital-based physician or hospitalist.

Studies aside, I firmly believe that when you are ill being treated by a physician you know and trust adds a major level of comfort. The fact that your personal physician knows what you look like in health gives them a distinct advantage in recognizing when you are ill. They know you and all about you and that helps. It especially helps patients with complex medical issues who require more time and thought.

Having your physician consult within his or her referral network of physicians, who know and understand your physician's expectations for communication and care, is an additional benefit. Being able to review the old records and previous specialty consultations which you were a part of seems to impart an advantage that someone just joining the care team does not yet possess. The point is, continuity of care can make a significant difference.

To be clear, this study does not say that outpatient primary care docs are better than hospitalists. It only illustrates that in a senior citizen population in 2013, patients cared for by their own primary care doctor had a better 30 day survival rate after a hospital stay.

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