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Health Status of Current U.S. Health Care: Two Cases in One Week

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Editorial

I have my solo cardiology practice for the last 15 years in Batavia, a small town halfway between Rochester and Buffalo, NY. I do see a fairly significant number of people with multiple cardiac problems. This area is served by good many internists, family physicians, Physician Assistants (PAs) and Nurse Practitioners (NPs). There are some PAs and NPs who work independently under the coverage and guidance of some other internists. For the last many years now we have a group of hospitalists working in the local hospital and for the most part, they do an excellent job serving the need of the hospital and the patients.

Due to the economic pressures, health care costs and political reasons, the hospital and physicians have been trying to find the ways to spend less and save more money. Many health insurance companies and the health care experts have been pushing to have more of PAs and NPs serving the population. Yes, with various guidelines in place, anyone can read them and try to follow them. However before any treatment can be offered to the patients, the right diagnosis needs to be made and that is where the real role of an MD comes. The health insurance companies, PAs, NPs, the computers and the guidelines cannot replace a well-trained MD and an expert in the specific field of medicine. That is what I will try to show by the following two real cases that I saw in one week in this small town.

1. A 61 year old white male admitted to the hospital on a Saturday due to the back and some chest pains. He said that while walking and then playing with his dog, he developed very intense back pains and some chest discomfort which eventually brought him to the local emergency room. His symptoms were relieved by Nitroglycerin paste. His ECG showed markedly inverted T waves in lead V2-4. There was no old ECG available for comparison. He claimed to see me about 8 years ago once in my office and since then he never came back for follow up. I was informed of these findings by the ER physician and he was hospitalized in stable and chest pain free condition. I was supposed to see him next day, Sunday in cardiac consultation.

I arrived at the hospital next day around noon to see a few patients in cardiac consultation. I wanted to start with him first because of his history of chest pains and the abnormal ECG the night before. After I arrived in his room, he was dressed up and ready to leave. Discharge papers were given and signed! I introduced myself to him and then I listened to his story and saw his last night and morning ECGs. His story was suspicious for Acute Coronary Syndrome; his both ECG were markedly abnormal and the one from the morning was unchanged as compared to the night before. His three troponins were borderline elevated. The computer readings of ECGs were clearly marked as abnormal!

He was being discharged on no medications: no Aspirin, no beta-blocker, no statin and no nitro! Why so? I put together everything and advised to the patient to stay in the hospital so that a cardiac catheterization can be performed in this setting. He was surprised to hear that. He said that the hospitalist on call said, "Everything was OK and I could go home!" Finally he did go home and did not want to stay for a valid reason: he had a dog and a few animals to be fed at home and there was no one that could do that for him. He understood the risk and consequences of leaving the hospital. However, he was discharged on optimal medical therapy and I arranged a cardiac catheterization for the next morning to which he agreed.

Next day, his coronary angiography showed 99% proximal Left Anterior Descending Artery (LAD) blockage which underwent angioplasty and stenting. He came for follow up a week later to my office and he has been chest and back pain free since then. Prior to leaving my office, the patient said, "Doc, you saved my life. I was going home without any medications. I would have gone to the woods as usual and would have died. So thank you!"

How and why did the hospitalist miss this serious and potentially fatal diagnosis? In cardiology textbooks, this kind of blockage can lead to massive heart attack and therefore proximal LAD stenosis is called a Widow Maker! How come the back pains and chest discomfort were not taken seriously by the hospitalist in the context of abnormal ECG and borderline elevated troponins? How come the hospitalist did not look at the computer reading of those ECGs? There is one thing that goes so very well with ECGs reading: What the mind does not know, the eyes cannot see! How come the doc could not wait for me to come to see the patient in consultation when the consult was already placed the night

before? How come the doc could not make a phone call to me saying, "Are you coming to see that patient and when?"

Health care is pushing these days more and more for the internists and the hospitalists to take care of these patients. The hospitals are being forced for rapid discharges of the patients. The current system is unfavorable for the specialty practices in an attempt to save more money, at times at the cost of human lives, the very same people who have been paying their health insurance premiums all along and unable to use the services when they needed them the most!

2. A 55 year old farmer was having chest pains for 5 days. Finally he decided to go to see his family physician. He was seen by a PA who did not fully understand the serious impact of his ECG changes. He called my office for this patient to be seen. Luckily we were able to see him the same day. His baseline ECG looked abnormal. He told me that his pains were quite bad 5 days ago but now it is much less but at the insistence of his family, he came to see a doc anyway. His ECG showed an acute event that probably must have started 5 days ago. I knew something seriously was wrong with that man. By then I also obtained the ECG performed by his PA. His 2D Echocardiography showed markedly hypokinetic LV apex. Just to have better assessment, I thought of giving him a very low level of treadmill exercise. Within a minute, his ECG was markedly abnormal and therefore the treadmill was stopped.

The PA who saw him did not understand the seriousness of his symptoms and implications of these ECG changes depicting a recent cardiac event. For the good luck of this patient, that he called my office for this patient to be seen. Imagine if for some reason or the other, if my office assistant would have said that the patient would get an appointment in 1-2 or 3 weeks which is not uncommon for many bigger or hospital based practices!!

I advised that we will take him to the local ER, right across from my office. I told him that very likely he had a heart attack probably five days ago. He said that he was feeling better and refused to go there. However, he was willing to go to a Cath Lab directly. He was given a pill of Aspirin, Plavix, and a Beta-blocker in my office. I called an interventional cardiologist. His daughter drove him to the catheterization lab right then and there. He was found to have 3-vessel CAD: 100% occluded Left Circumflex artery with right to left collaterals, 95% proximal LAD and 80% mid-RCA. He required two arteries to be stented. He is doing well upon follow up.

ECG interpretation is a major weakness of many internists, most family physicians and hospitalists and almost all PAs and NPs. Most of them rely on the computer readings to base their day to day decisions. It is not uncommon for me to see one or two patients daily referred to me to be seen for an abnormal ECG while in fact, almost nothing is wrong on those ECGs. On one hand, I do not expect them to read the ECGs thoroughly at any level and that is fine, however on the other hand, this is becoming a reality of medical practice that more and more patients in general and cardiac patients in particular are being cared by the family physicians and the physician extenders.

Physician extenders are supposed to do certain work and unfortunately we continue to extend their jobs left and right. There has even been a discussion to have many more of them and far fewer MDs to run the US health care. I remember there was a time when many health insurance companies refused to pay the reimbursement for the internists and cardiologists' interpretation of ECGs! Their logic was that we are getting the computerized ECG interpretation and so why to pay the doctors for their reading the ECGs. After a while when they realized that the computer reading of ECG could be so wrong so many times and that someone needs to supervise it that they restarted to pay the doctors' their due fee, however bare minimum.

It is my firm belief that both of these patients would have died if they did not get intervened by cardiology consult in such a timely fashion. Contemporary US health care is pushing for merger/buyout of private practices. I can very well say here that physicians might not have the incentives to work that hard for a hospital or corporation based practice. It is totally unfortunate that the current trend in medical care is driving doctors to sell their very private practices for which they worked so hard. My practice is in a very small town. I am always on call for my cardiology practice 7 days a week round the year unless I am away which happens so infrequently. I give out my cell number to the hospital and paging service even if I am out of town and I get called no matter where I am. This I have been doing for the last 15 years- day and night, weekends and holidays. I am sure you can imagine I probably would not have practiced cardiology this way if I was working for a hospital or a corporation. In today's business model oriented medicine run by the executives, not only the doctors' reimbursement is being reduced drastically but also their zeal, enthusiasm, and pride are taken away and above all, in this current era of practicing medicine, the patients are going to be hurting the most. Sadly at this stage, the process seems to be more than irreversible!!