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O N E

WHAT'S HAPPENED TO HEALTH CARE?

Financial ruin from medical bills is
almost exclusively an American disease.
—Roul Turley

My doctor is nice; every time I see him I'm ashamed of
what I think of doctors in general.
—Mignon McLaughlin

During my lifetime as a physician, medicine and the delivery and financing of health care have changed so drastically that I sometimes find it difficult to recognize my own profession. I introduce my concern with a brief personal history. In 1955 I started out as a general practitioner in rural Wisconsin, charging $2 for an office call and paying only $60 per year for malpractice insurance. By contrast, in today's market some readers may have been billed over $1,000 for an office or clinic visit plus laboratory work—before insurances or Medicare mandated a steep reduction. (If you don't have Medicare or an insurance company to negotiate for you, payment of the full bill is required.) And some readers probably have heard on the television evening news that for certain medical specialties, malpractice insurance may cost $100,000 to $200,000 per year.

More personal history. I was one of those old-fashioned country doctors, trying to do everything in medicine, often doing more than my level of training should have encompassed. Eventually, I realized that no one is smart enough to do what I was attempting. Medicine was moving too fast. So I specialized and superspecialized, becoming both a cardiologist and a geneticist—a medical school professor, caring for patients, doing research and

teaching, becoming active in heart transplantation, and writing medical books in both cardiology and genetics.

THE PLAN OF THE GUIDE

This book is a guide, only a guide, to the points I consider most relevant—at least from my own experience. It will not cover all the medical and social issues important to seniors. It will not even cover in substantial detail many of the topics it introduces. But it will discuss, however briefly, the ten leading causes of death and disability among patients over age sixty-five and many other related and unrelated diseases and social problems for seniors of varying ages. You may feel too much attention is paid to diseases of the heart and blood vessels—even though they account for more deaths and disability than all the other leading causes combined. As a cardiologist I find it difficult not to expound on the topic closest to my heart—pun intended. Also as a cardiologist I take great satisfaction in noting that deaths from cardiovascular diseases have diminished greatly over the last three decades, according to a January 2003 report in *Reuters Health*. Of particular interest to my fellow seniors is that the typical cardiac event is less often a fifty-year-old man dying suddenly with a heart attack and more often a seventy-year-old man or woman sustaining a heart attack—*and surviving*.

As you read, you may find what you consider to be glaring omissions. Why didn't I even mention conditions A, B, or C or diseases X, Y, or Z? My emphasis is on prevention, not treatment. Treatment is what your doctor does. Why isn't the latest information on this or that included? One reason is that on the very day of publication, a book at the cutting edge of information on a subject is already out-of-date in some areas. That's where the Internet, TV, and newspapers may be useful. (Frequently, I give dates on specific information so you will know how old it is.) As a guide, however, I hope to point you in the right direction and help you and your doctor by making you a more knowledgeable patient. To supplement the material I do not cover in sufficient detail (or at all), I'll provide fairly extensive lists of resources, most often at the ends of chapters but also in a bibliography at the end of the book.

In writing textbooks for two rapidly moving fields of biomedical science, I have always tried—as I will try here—to present the latest information right up to the time of publication. The problem for this book is that not only is science advancing rapidly, but the rules and the current health care activities in government and the insurance companies, which I must also discuss, change almost daily. You should also know that infor-

mation I present in this and later chapters may be more technical than some readers care to pursue. When explaining certain material to patients face-to-face, I can see if they're tuning me out, so I simply pass lightly over the subject. Other patients ask me pointed questions. I'm therefore going to provide a few details for such questioning readers and advise those who prefer to skim when it's all right to do so.

WHO IS A SENIOR?

You need to be fifty (an age that now includes baby boomers) to join the American Association of Retired Persons (AARP). So I take that as the beginning of the target age for this book. For purposes of Social Security and Medicare, you qualify at sixty-two and sixty-five, respectively, but the threshold for age of eligibility for *early entry* into Social Security is increasing two months each calendar year. In other words, you have to be two months older next year than you do this year to enter the system. If you're a man over seventy (which I am), you may be entitled to use the term *geezer* as well as senior (as sort of an advanced degree). On the flip side (that dates me, CDs don't have flip sides), an all-too-familiar tune plays—you could even be a "senior" as early as your forties, when your hard-earned raises have put you in an income bracket that makes you a target of downsizing and unemployment or underemployment. Too high an income encourages bean counters to discount the contribution of workers in their most productive years in favor of younger economy models. Does all this mean baby boomers will find guidance in the pages that follow? Yes. You've come a long way, baby boomer.

What can a geezer share with fellow seniors? For me, there's been a sense of surprise. I frankly never expected to become a geezer. As a cardiologist interested in the genetics of heart disease, I did a calculation over twenty-five years ago based on my understanding of risk factors at that time and determined that my life expectancy should have been about age forty-three. Since I'd already surpassed that prediction, I decided to take vigorous steps to continue to advance my longevity even further. (It has been documented repeatedly—most recently in 2002 in the GENECARD project—that except for very rare gene mutations, even familial premature coronary disease still thrives on risk factors such as smoking, diet, and high blood pressure.) I learned much more about prevention and shifted an emphasis of my research interest away from crisis care—including heart transplantation—to preventive cardiology.

You've really got to be a senior to understand clearly the problems of health and life management that perplex older people. For example, it is

now difficult to find a physician who can take care of most of your medical needs. Also, you will not be charged $2 for an office visit. Last week I had an appointment in an allergy clinic where I saw a doctor in training who was eventually checked by a staff doctor. The history of my allergy was taken, a stethoscope was placed on my chest, and some blood was drawn for laboratory studies. The cost: $1,168. Prudently, Medicare would not accept the exorbitant charge. They paid $142. But if these sorts of problems can perplex an "old" physician, what can the layperson expect?

Of course, the younger you are when you embrace healthful living, the better. And the more you know about yourself and your family, the better. Wearing my geneticist hat, I'm going to emphasize immediately that diseases run in families. (You already knew that, didn't you?) Hippocrates appreciated this fact almost 2,500 years ago when he wrote concerning the cause of epilepsy, "Its origin is hereditary like that of other diseases." So here's a recurring theme: in each section of diseases that will be discussed, familial implications must be kept in mind. And in the case of seniors, this is not just so you are aware of the illnesses that afflicted your parents and siblings and other older relatives, but it's to let your children and grandchildren know about the illnesses you've experienced so they can take timely steps in prevention.

FINANCING HEALTH CARE FOR SENIORS: PROMISES AND PITFALLS

As much as I'd like to, I can't go right into the topics of disease prevention, optimal health care, and healthful living because everything in health care is now so costly. And what if a senior can't afford good health care? (Too many can't.) Therefore I feel I should share some background and problems about health care financing and delivery.

If this topic is not important at this time of your life or if I'm telling you more than you care to know about this subject, please skip to the next section, The Quality of Medical Care. Some definitions. I often use SS for Social Security and HMO (health maintenance organization) as shorthand terms for managed care, which also includes PPOs (preferred provider organizations) and other organizational structures. One hundred sixty million Americans are enrolled in some form of managed care. HMOs are relevant for seniors under age sixty-five and for seniors older than that who are on Medicare and who deal with managed care through Medigap insurance or through electing HMO coverage through Part B of Medicare, which then pays the HMO a fixed sum per enrollee. If you're already in an HMO, at sixty-five you can directly enter Part B Medicare

coverage in your current HMO (if it hasn't terminated Medicare HMO coverage).

Medicare/Medicaid came into being in 1965 as part of Lyndon Johnson's Great Society Program, and the cost has been rising at the current rate of $20 billion a year to its present annual level of $300 billion. Enrollment in Medicare, which now covers about 39 million Americans, is automatic if you have Social Security or Railroad Retirement benefits. If you have not been covered by either of those plans, you have to apply for Medicare starting three months before you turn sixty-five and extending for seven months as the initial enrollment period. You may apply at and get the rules from any Social Security Administration office.

Private health insurance began only a few years before Medicare. During the summer of 1950, just before starting medical school, when I was going from door to door and farm to farm selling health insurance, I never would have guessed what a monstrosity the insurance industry and managed care would eventually become. Later, during my time in country practice, we didn't send bills; we kept a record, and the patients would pay when they had the money. Today a doctor's office often has more people involved with insurance forms and billing than in delivering care. Would I be willing to give up the high-tech advances in medicine to return to a sentimental Norman Rockwell vision of medical practice? Of course not. I participated in developing some of those advances.

Is there a middle ground? I believe so. And I want to be up front with you: I don't want you to fear getting medical care. Demand the best care you can get now—and I hope you will work to improve the system. We geezers vote. And lobby. And contact our politicians. We can make changes. We must. During the past three decades, health costs have soared out of control. Managed care was one approach to this potentially disastrous (insurance-initiated-and-fueled?) threat to our economy. I take the advocacy position that many leaders in health insurance, HMOs, and pharmaceutical companies are prepared to defend their economic advantage by the most egregious, if not dishonest, methods (in alliance with their congressional supporters). Remember the Harry and Louise TV commercials that spoke against universal health care? The dire predictions of what would happen if the government provided a basic health plan for everyone?

Pitfalls in Health Care Delivery

But those very predictions were already taking place, with insurance companies, pharmacy-benefit companies, and HMOs doing the dirty

work. What was so dishonest was that many of the horrors Harry and Louise were describing on TV do not take place in a universal health care system such as Canada's, but they *do* take place in the United States under the supervision of HMOs and health insurance providers in a for-profit system. Most of you will be more interested in the optimal health care aspects of this book. But for those who lean toward activism, I'll discuss a few more pitfalls in today's health care financing and delivery and refer you to two books listed at the end of this chapter—*Bleeding the Patient* and *Health Care Meltdown*—from which much of the data in the following pages can be found.

Recently, another actress on TV, the elderly Flo, starred in a $30 million campaign quietly funded by the drug companies and their allies under the deceptive title Citizens for Better Medicare. "I don't want big government in my medicine cabinet," Flo indignantly pitches to the TV audience. But just a minute, Flo; who runs Medicare, the very program that has been providing seniors with health care? Why, it's big government, of course, in or out of your medicine cabinet. But Flo became a little less obvious in a later round of commercials. Now the drug and insurance companies have decided they'd like a piece of the prescription drug action through government subsidies, so they deceptively attack the Canadian system for using lower-cost prescriptions as if that is responsible for delays in elective surgery in Canada—when in the United States our HMOs and insurance companies force similar cost cuts and some delays in surgery.

So how about rounding up another usual suspect in the Harry and Louise and Flo melodramas? The pharmaceutical industry. The truth is that the pharmaceutical companies don't want government to lower their profits. They fight to delay patent-name drugs from going generic and selling for a fraction of the former price. According to the Public Citizen Health Research Group, average prices for prescriptions have doubled in the past ten years, making prescription drugs the fastest-growing component in health care inflation (up 17 percent each year). The Health Care Finance Administration revealed that from 1990 through 1998, annual prescription drug spending rose from $38 billion to $91 billion—and continues to rise. Public Citizen has also recently determined that Americans pay, on average, twice and up to seven times as much for the same drugs as is paid in the other industrialized countries surveyed, all of which have universal health care and with it a control on profiteering (amoxicillin costs 83 cents a tablet in the United States, compared with 12 cents a tablet outside the country). Busloads of seniors cross the border into Canada to fill their prescriptions.

A standard explanation for the high cost of drugs in the United States is the need to invest in research. Baloney. More money, according to the Health Research Group, is now being spent on advertising and marketing (30 percent of revenues) than on research (20 percent of revenues). One example: advertising and marketing for the statin drugs (such as Zocor and Lipitor) we take to lower cholesterol cost $2.8 billion in 2001—for just that one small group of drugs. And are we to believe that no research is being conducted outside the United States where some of our major drug companies are actually European-owned and where drugs are so much cheaper? British companies count on making major profits through selling their products to the United States at higher markups than are permitted at home. Even the House of Representatives couldn't stomach the overcharging by U.S. drug companies (which spend more than any other industry—$197 million in 1999 and 2000 alone—for lobbying and political influence), so it passed a bill to allow Americans to fill prescriptions abroad.

What Harry and Louise and Flo didn't tell us is that huge pharmaceutical companies may also run the subsidiary pharmacy-benefit programs used by insurance companies. These benefit programs delve into your personal and private medical history by going through your prescriptions and may contact you to *insist* on what medications or treatments you should have if you want to continue to use this or that category of drugs. The *Washington Post* had an article on this subject that described a woman who was quietly having her depression treated with medications her doctor felt to be appropriate. She did not want the fact that she required treatment for depression to be known outside the doctor-patient relationship. But the pharmacy-benefit company knew. It had other ideas and contacted her to prescribe its own course of treatment. The inviolable doctor-patient relationship seems as much in the past as my old two-dollar charge for office visits. By contrast (take note, Harry and Louise and Flo), that big-government program Medicare cannot release information about patients without their consent, in compliance with the Privacy Act.

Pharmacy-benefit managers can also change your prescription without your consent. Our medical school's health insurance program contracted with PCS Health Systems, formerly owned by the drug company Eli Lilly & Co., to manage our pharmacy benefit. The cholesterol-lowering drug I used to take was Zocor made by Merck & Co., which also owned a rival pharmacy-benefit program, Merck-Medco. Well, PCS refused to pay for Zocor made by this rival company and substituted the

cholesterol reducer Lipitor. The company did this even to a medical school professor who is a cardiologist and was having excellent results from Zocor, with few side effects. Fortunately, it turns out that Lipitor works even better for me than Zocor did. So I suggested that my wife switch to Lipitor. Guess what? Her pharmacy-benefit program, Merck-Medco, wouldn't pay for the rival product Lipitor but will, of course, pay for Zocor. (A word of warning on these "statin" drugs: do not stop taking them abruptly and completely. A heart attack could result. *Talk to your doctor.*)

In preceding paragraphs I've used the dirty words "universal health care." Think about it. Every other industrialized country except South Africa, as well as many developing countries, has universal health care (or the dirtier words "socialized medicine," meaning the same thing)—but not the United States. Ask yourself why. Better still, if you're inclined to activism, ask your elected representatives why. Ask why we pay a higher percentage of our gross domestic product for health care than any other industrialized country, all of which have the security of universal health care—*that means care for everyone in those other countries*—yet over 40 million Americans are without health coverage while U.S. health care costs in 2001 were $1.2 trillion.

As I write this, the electronic and print media are filled with stories of abuses of managed care and insurance providers because a patients' bill of rights is again under congressional consideration. Abuses include denial of access to specialists and to other appropriate or even necessary care, delays in approving life-saving procedures until the patient dies, forbidding doctors to disclose to patients medical care options the HMO has ruled out of bounds, refusal to pay for emergency room (ER) care that has not been preauthorized—and all of this under a blanket of protection managed care plans enjoy against lawsuits for malpractice. Consider the experience of a young woman who fell off a cliff while rock climbing. She was airlifted to an emergency room, unconscious, with multiple fractures of the skull, arms, and pelvis. Her HMO initially refused to pay the $10,000 hospital bill because although she was unconscious on arrival at the ER, she had failed to obtain preauthorization before going to an emergency room. In 2001 HMOs' premium rates were triple the national rate of inflation while providing childhood immunization for only two-thirds of their patients and blood pressure control and cholesterol management for only half their patients, even after a heart attack. However, in July 2001 Blue Cross of California decided to reward doctors for quality of care and patient satisfaction instead of exclusively for cost cutting. It's a start. And we'll see how many other HMOs

will follow—kicking and screaming—and how this will influence Congress to act on a true patients' bill of rights.

For the patient, fear is the operative word. Workers desperately fear losing their jobs or changing jobs before Medicare coverage begins. Being without health insurance is one of the great threats to Americans' sense of security. So along comes the Kennedy-Kassenbaum legislation that mandates the right to purchase health coverage. But my fellow senior, you know what happened, don't you? The providers may now have to cover you, but they can charge what they want—which could easily be much more than a family can afford. I hope that enormous loophole is closed by the time you read this.

This is not to say there are not some good HMOs. Many of the plans are compassionate and offer a high level of comprehensive and preventive care. I'm not on the payroll of the Kaiser plans, but from my personal experience and from presumably objective outside evaluation, they rank at or near the top in all the markets they serve (although they recently suffered an acrimonious strike in Colorado). *U.S. News & World Report* annually rates colleges, graduate schools, and hospitals. It's also rated HMOs. Some states, such as Massachusetts, have an abundance of four-star plans. Other states have no plan rated higher than three stars. However, most patients appear satisfied with their plans.

But it's the horror stories that are receiving attention in Congress and on the national news. The obscene multimillion-dollar compensations for the chief executive officers of some for-profit plans can never be justified, especially at the very time they are denying their patients their legitimate benefits while increasing the costs to those patients. A study in 2002 looked at the quality of primary care for Medicare patients in HMOs versus fee-for-service (FFS) plans. It found that the quality of care was higher in FFS plans, but so was the cost. However, the money-saving advantages of managed care may be disappearing as the plans aggressively raise their prices—as high as 20 percent this year for one health care plan. HMO stocks, the darlings of Wall Street with their 32 percent annual returns until recently, are beginning to tumble. Seniors would do well to look for an objective rating (such as that of *U.S. News*) of their present or future managed care companies. But at the end of 2000 another half dozen HMOs opted out of Medicare, leaving almost a million former patients scrambling for coverage. In some areas there are no alternative HMOs, or those that remain are unable to add new patients to their already full capacity.

On balance, unscrupulous people have fraudulently ripped off insurances (particularly Medicare and Medicaid). In fact, the magic formula

for reducing the cost of Medicare/Medicaid and health care in general by billions of dollars a year has been enunciated over and over: eliminate waste, fraud, and abuse. (Recently, Ralph Nader stated that fraud costs the entire health care system $110 billion per year). Fraud is self-explanatory. An example is an infamous HMO caught "cooking its books" on Medicare charges. It turns out that fraud is potentially so lucrative that organized crime has been reported to be moving in for a piece of the Medicare/Medicaid action. Something that borders on fraud is the practice of many doctors and hospitals (and dentists) to "unbundle" and upgrade charges. Forms of waste and abuse of the system include overutilization and improper utilization. Of course, HMOs and health insurance companies focusing on their bottom lines would rather not have to deal with sick people or old people. What a break for the companies to have Medicare cover seniors who need care that could damage the bottom line of private insurances. However, some seniors are quite healthy. They're the ones to go after with proposals for so-called medical savings accounts that permit "cherry picking" rather than more evenly distributing the burden. Could privatizing *all* the picked cherries to increase the insurance industry's profit be far behind?

The trend had already started with the big managed care companies constantly soliciting seniors to use Part B of Medicare to enroll in a private plan. The companies thought they were on an unlimited 10-percent-price-increase-per-year gravy train. Then Medicare said, you get only a 2 percent increase in prices next year—and what happened? The companies that had been bombarding me every week to turn my Part B of Medicare over to them dropped Medicare in a snit, leaving the patients they had aggressively solicited to find other care. From January 1, 1999, to January 1, 2001, about 1.4 million beneficiaries lost their HMO coverage through Medicare. Too bad. Business is business. And for-profit managed care is definitely a business.

The existence of Medigap insurance acknowledges that Medicare, as expensive as it is to the wage-earning taxpayer, does not cover the costs of health care. By the way, if you've been retired for only a few years, you're probably already taking more out of the system than you put in during your entire working life. It's today's wage earners who are paying for you. I'll discuss this later.

Description of Medicare

The details for you as a beneficiary are provided in publications entitled *Your Medicare Handbook* and *Medicare and You 2004*, the latter of

which is the latest edition at the time of writing. These booklets, which are sent to you as soon as you become eligible, have many pages of phone numbers to call for help on specific Medicare questions, so I won't repeat those numbers here. To review briefly, Part A of Medicare is hospital insurance. Anyone who worked and accumulated enough quarters on the job to be eligible for Social Security or Railroad Retirement automatically qualifies for Medicare. Others have to apply when they are about to reach age sixty-five. A beneficiary is entitled to a certain number of days of inpatient hospital care but must pay a deductible, which seems to increase every year. If the hospital stay exceeds the entitled amount during a benefit period, co-payments are required. But for other charges, such as prescription drugs, there is currently almost no benefit. Medigap plans will pay the deductibles, co-payments, and some other charges not covered by Medicare. Yet Medigaps have their own deductibles and co-payments.

Part B of Medicare is optional supplementary medical insurance, which 95 percent of beneficiaries elect to carry in addition to Part A. The premium is deducted directly from the Social Security check. Part B covers services provided by a physician and other approved health care professionals. Medicare sets the allowable charge for the service and pays 80 percent of that amount after the deductible is paid. You'll find many more details of the complex workings of the plans in *Your Medicare Handbook*. There are serious limitations to Part B, particularly in preventive services. Some bean counter must have calculated that it was more cost-effective to deny the test for early detection of prostate cancer (prostate-specific antigen, or PSA) to all beneficiaries than it is to pay for treating a few thousand men a year with more expensive surgery, radiation, and hormone therapy for the advanced disease they may get because of not having early detection. I'm expressing a personal bias here regarding prostate cancer. To be fair, there is a legitimate argument against testing, particularly in older men, that goes like this: most older men will die *with* prostate cancer but not *from* prostate cancer. Fortunately, Medicare now covers PSA.

Where it gets confusing is how to decide whether to have your own Medigap insurance, which many workers receive as a retirement benefit, or to let an HMO take over your Part B and provide many items Part B may not offer. About 15 percent of patients on Medicare have elected to have an HMO serve as their combined Part B and Medigap. If you receive Medigap as a retirement benefit, the choice, at least for me, is easy. If you have to pay a sizable Medigap premium to avoid the hassles and restrictions of the HMOs, your financial state will be a deciding factor.

But once more I warn you that some managed care companies are opting out of Medicare coverage, leaving the patients they persistently solicited to find other care. *And most frightening of all is not to have insurance before you're eligible for Medicare but when you are not eligible for Medicaid.* Hospitals are required to accept emergencies (with long delays), but some have waiting lists for nonemergency admissions that make the Canadian system look supersonic.

Recent Changes in Medicare

If you're on Medicare, you've probably received the publication *Medicare and You 2003* that details the options available in many areas. These include the Original Medicare Plan that most of us are on (the plan available in all areas) and the Medicare + Choice Plans, which include Medicare Managed Care Plans (such as HMOs) and Medicare Private Fee-for-Service Plans. The information in your booklet on Medicare + Choice should be studied carefully before making a decision.

Another decision will have to be made before 2006 if the prescription drug plan being debated in Congress goes through in one of its current forms. A goal of the present administration is to privatize Medicare completely. A first step would be to privatize a prescription drug plan for Medicare beneficiaries. Most Democrats and the AARP oppose the plans being hyped by congressional leaders and the president. The opposition hopes that even if the legislation is signed, it can be overturned before 2006. If not, seniors may be asked to decide on a private plan, which will cost premiums and offer less than optimal benefits. My choice would be to stay with my present Medigap insurance.

Doctors and hospitals do not like Medicare, which approves only a fraction of charges. Many doctors refuse to take Medicare patients, as do some hospitals. A minicrisis in our own University Hospital has just been averted. For a short time it appeared that for reasons of fiscal prudence, the hospital in which we as physicians devoted our professional lives would not accept many Medicare patients, including us. Our Retired Faculty Association won a commitment that we would still be accepted.

As a segue to the next section, there is a debate concerning the ethics of recent developments in the delivery of managed care. Since Hippocrates, the focus of medicine has been on the individual patient, and a 1995 American Medical Association ethics report reaffirmed this approach. Surprisingly, at least to me, is that there is some support for a population-based system of ethics to distribute care among members of a managed care plan to achieve the best overall results *within* that plan,

even if it means some would receive minimally acceptable rather than optimal care—in deference to achieving a satisfactory bottom line. I'm strongly opposed to "minimally acceptable."

THE QUALITY OF MEDICAL CARE

I wish I didn't have to write this section, but we must face the fact that even if you have become familiar with the problems of financing discussed in the previous section and can afford optimal health care, you may not get it. To me, the quality of medical care today is even more important than the cost. I don't want to frighten my fellow seniors, but I have to share a recent study from the National Academy of Sciences, which you may have seen on television. The number of medical errors, both fatal and nonfatal, made every year is alarming. In hospitals alone, between 44,000 and 98,000 patients die annually because of medical errors and accidents—that's more than are killed in automobile accidents, more than die of breast cancer or AIDS. A medical ethicist asked the all-too-relevant question: Can we simultaneously reduce costs and the risk of error?

We've got the high-tech gadgets and breakthroughs, which your managed care provider may or may not permit you to use depending on the decision of the gatekeeper—but where is a doctor who has the time to know all about you? Such a doctor is sometimes hard to find. For seniors and patients of every age, it's important to have your own doctor. And your doctor should participate in decisions made by other doctors who may be treating you for various conditions in their specialized areas of expertise. You need a colonoscopy? The doctor to whom you've been referred sees a polyp and decides to snip it out. Does he know you're taking Coumadin and could hemorrhage from his snipping? (This error is highly unlikely; before your colonoscopy, you should fill out a history form that will ask if you are taking Coumadin or even aspirin.) But *don't assume anything.* You're taking drug A for condition X. Your consulting doctor feels you need drug B for condition Y. Does the consultant know you're on drug A, which *never* should be taken with drug B? *Don't assume anything.* And as hard as it may be for you to understand this, even if he or she knew you were being prescribed both drugs A and B, the doctor possibly *may not* know they shouldn't be taken together. Pretty scary, isn't it?

Of course, your own doctor can't be at your beck and call twenty-four hours a day, seven days a week. I've done it for prolonged periods, and I know there are physical, emotional, and intellectual limits. Frankly,

I was so stressed being constantly on call during four years of country practice that it was one major reason I decided to specialize. I commiserated with my son (when he was working 110 hours a week with one or two days off per month as a resident specializing in internal medicine) and told him that at the end of the first week of my own internship, I was afraid I was going to die. But at the end of my second week, I was afraid I *wasn't* going to die. A physician cannot be effective if he or she is too exhausted to think straight or has no life outside of medicine. This situation contributes to many errors. We have to be able to renew ourselves and raise our families and enjoy the harvest of our labors. Solo practitioners in small communities burn out quickly. A physician has to have backup, interactions with other physicians, and downtime with adequate nights and weekends off and vacations.

If your own doctor is away, his records should be available, but you should also be able to provide the information noted in the next paragraph—information you should always have in your possession. Ideally, for elective procedures, such as the aforementioned colonoscopy, there should be an informing interaction between the doctors collaborating in your care.

So what should the patient do? *Take charge*. Know and write down your medical history. Know every medication you're taking, including over-the-counter drugs; why you're taking each one; how much you take; and for how long you've taken it. Whenever a new medication is prescribed, whip out your lists and ask the doctor how the new medicine will affect other conditions you may have (for example, asthma); how new medications will interact with drugs you're already taking in the dosages for all medicines, old and new, prescribed and over-the-counter; and what the interaction with foods may be. And if a drug is new on the market, for me the "five-year rule" should apply. *Unless a new drug is vital to saving your life and your health, don't take it until it has been on the market for five years and the adverse effects have been identified.* Rest assured, many doctors will consider you a pain in the butt. The insecure ones will feel threatened. Too bad.

A provocative 1998 article by Marc Fisher in the *Washington Post Magazine* walks my recommendations about taking charge many steps further. He discusses the fact that some HMOs and insurance companies prefer that patients get the answers to their medical questions from the Internet rather than annoy their doctors with a lot of calls. He even notes that some doctors feel they are so rushed that they urge patients to do their own research. Presumably, once the patient has made his or her

own (let's hope) correct diagnosis and decided on the proper course of treatment, he may report these findings to a physician for confirmation and appropriate action. (I'm exaggerating a little to make my point.)

Over 40 million Americans now use the Internet, but although seniors make up 27 percent of the population, they represent only 13 percent of online users. The computer revolution passed by many of us. However, *Modern Maturity*, the magazine of the AARP, ran a cover story on the growing use of computers among seniors and has advertisements that say you can learn to access the Internet in one day. There are 25,000 health sites on the World Wide Web, so seniors with computers and Internet skills (or children or grandchildren to teach them) may get useful information from legitimate sources such as the National Institutes of Health. Those who become addicted to the Internet may prefer it to 800 numbers. If the resources I provide in the sections that follow have only street addresses and phone numbers, you may be able to get an update and a Web site by calling the 800 number. If you don't have a personal computer, you can get online at your public library or senior center.

The Internet address (Web site) of the National Institutes of Health is http://www.nih.gov. Most of the time you won't need the introductory http://, so from now on I'll just give Web addresses starting with www. If that doesn't work, add the prefix http://.

Unfortunately, a lot of "online medicine" may be a minefield for the unsophisticated and unwary. Anyone can go online and claim to be an expert, but the so-called medical adviser could have no relevant skill beyond the ability to access the Internet to display his or her misinformation.

At the end of this and other chapters, I list many online addresses useful for seniors. But my preference is still books. It's quicker to look something up in a book than to try to get onto the Net and put up with the delays and disconnects. I'll mention several books in this presentation. One book, *The Merck Manual of Geriatrics*, which covers diseases and related issues for the elderly, is an incredible bargain ($25, 1,500 pages). It's designed for physicians and other health care professionals but may be used for reference by many seniors. The print is so much larger and darker than that in *The Merck Manual of Diagnosis and Therapy* that it makes me believe the publisher deliberately designed it to be read by seniors (senior doctors anyway). However, a similar book by the same company covers conditions of patients of all ages, is intended to be read by laypersons, and adequately and clearly describes most relevant problems of seniors: *The Merck Manual of Medical Information* ($29.95, 1,500 pages). This is the Merck manual I suggest you get. There is also a paperback

edition for $7.95, but seniors may find the print too small. If you can't find it on the shelves of your local bookstore, the store can order it for you. The paperback edition may also be in your supermarket and drugstore.

If you are a newcomer to the status of senior, you might be uncomfortable with the term *geriatrics* referred to in the title of the first book mentioned. Although there aren't enough of them to go around, patients in their seventies and above might find a physician who specializes in geriatrics. Such a physician has made a decision to care mainly for seniors and has taken training, passed an examination, and obtained certification of special competence in geriatrics. He or she should not only be more knowledgeable about older patients but be more attuned to their special needs than other doctors are. Specialists in internal medicine and family practitioners, in that order, if they take a sincere interest in seniors, can also do a good job. My personal physician is a knowledgeable specialist certified in both internal medicine and geriatrics.

MEDICATIONS

To help seniors navigate more safely through present-day health care, I must discuss medications before delving into medical conditions. I've seen the estimate that around 100,000 patients die every year in America not from their diseases but as a direct consequence of the medications they're taking. (I'm not sure how that statistic was arrived at, but another estimate reported by Reuters Medical News Service in July 2001 reduced the number to 5,000–15,000, which is still unacceptably high.) A case in point: several years ago my mother-in-law, in her eighties, was having more problems than her family doctor could cope with, so he referred her to a specialist in geriatrics. The first thing that physician did was discontinue almost all of her many drugs. Her improvement was immediate and remarkable.

Like my mother-in-law, those who have lived to be older seniors have likely acquired a number of chronic conditions, so on average we regularly take four to five prescription drugs and three to six over-the-counter drugs. Some are necessary. Some are not.

Let me give you a deliberately exaggerated hypothetical. You have pain in your fingers from arthritis. To relieve the pain, you take one of the newer non-steroidal anti-inflammatory drugs (NSAIDs) you see advertised on TV and that are being used liberally by doctors, but you don't take it with food and an acid reducer. (I'll discuss NSAIDs more in Chapter 7.) Your doctor detects that your blood pressure is going up (but he doesn't realize it's secondary to taking the NSAID), so he pre-

scribes an expensive antihypertensive drug (an ACE inhibitor). Soon you develop an annoying cough (from the ACE inhibitor), which keeps you awake at night and requires a cough suppressant that only relieves the cough for short periods. Later you notice edema, puffiness of your feet and legs (also secondary to the NSAID), so you receive a prescription for a diuretic. (Actually, the diuretic alone would probably have been enough to reduce your blood pressure—*not that any drug was really needed in the first place*.) You begin to experience the minor problem of constipation (from the diuretic and the cough suppressant) and have to add a laxative to your drug program. Then come the major problems. You could feel faint and fall (from the antihypertensive drug and the diuretic, which is also an effective antihypertensive drug) and break a hip. Or you could get a bleeding gastric ulcer from the NSAID and end up in a medical intensive care unit getting blood pumped into you. At some stage you could die. You took all those drugs for a minor problem or for problems being caused by all those drugs—when all that was needed was for you to *stop* taking the drugs going all the way back to *stopping the one drug that started the whole medical nightmare*.

> A little Tylenol or accepting some pain as part of being alive could save your life. The First Noble Truth of Buddha is that life is pain.

So the lesson as far as I'm concerned is, *the fewer drugs the better*—especially the psychoactive drugs that influence mood and behavior, drugs that make the patient more agreeable to caregivers, less feisty. But feisty is good. The patients who live longer, with a higher quality of life, are feisty as hell. It's the docile ones who die sooner, quietly, not wishing to be a burden. A term that's commonly used is *polypharmacy*, the use of many medications at the same time. Older patients often have multiple conditions that require treatment with multiple drugs. Older patients also, all too frequently, receive more medications than they need, sometimes in a chain reaction of one drug to counteract the side effects of another drug and soon a third drug to treat the unwanted effects of the second drug and on and on until someone says, let's see how the patient will do without any of these drugs. And in the case of my mother-in-law, the patient did much better, thank you.

Relevant Publications

More books I'd like to recommend at this point are a small medical dictionary and *The PDR Family Guide to Prescription Drugs* ($23). The

latter is much less expensive than the standard *PDR* (Physicians' Desk Reference), but it contains over 800 pages of valuable information. However, it's not quite as up-to-date as the standard *PDR*. There is also a *PDR Pocket Guide to Prescription Drugs* ($6.99), which has smaller print and appears to have less material, but you can buy it at your drugstore. For seniors, the *PDR* I suggest is the *PDR Family Guide to Prescription Drugs*. Look up the drugs you're taking, see what they're used for, read how they act in your body. You may discover, as I did with a patient who recently talked with me, that you're taking three drugs that do the same thing in approximately the same way. You're thus getting three times as much drug as you should safely take. This patient was taking three "blood thinners" that act on platelets and was rewarded with a severe hemorrhage that landed him in the hospital.

The beauty of this *PDR Family Guide* is that for each drug there is a subheading titled the "most important fact about this drug," and it gives foods, beverages, and medications to avoid while taking a particular drug. I wouldn't advise testing your doctor on the subject (you might make him defensive), but I bet most doctors would be unable to remember many of the avoidances without looking them up. (To get a feel for the information in the *PDR,* look up what to avoid with Nardil, a commonly used psychoactive drug. Amazing, isn't it?) Then, armed with your reading material, be ready to ask educated questions of your doctor and pharmacist, bearing in mind the warnings of adverse drug reactions—including those interactions between drugs and with foods that you assume your doctor knows about, but he or she may not.

As for medical dictionaries suitable for laypersons, there are several possibilities including the *Random House Health and Medicine Dictionary* ($7.99), *The New American Medical Dictionary and Health Manual* by R. E. Rothenberg, MD ($6.99), and *Bantam Medical Dictionary*. The type in the Bantam is too small for me, so I'd advise one of the first two.

Drugs and Aging

Something you and your doctor should appreciate is that getting older influences the way you react to drugs. Elderly patients are twice as susceptible to drug reactions as younger adults are. The aging kidneys and liver contribute to the problem. The relative quantity of water in the body decreases and thus is not as available to dilute the medication, and the kidneys are less capable of excreting drugs. The liver is also less able to metabolize drugs. I mentioned Coumadin earlier. The dosage of that drug suitable at a younger age is too high a dose in an older person

because of the effect of aging on prothrombin response. Another example: less morphine is needed for pain. Many drugs stay in the body longer, so a rule of thumb is lower doses further apart for most drugs and most seniors.

There are special problems for seniors and patients of all ages in hospitals (and especially for seniors in nursing homes). You mustn't think you're safe because you're in a hospital. Far from it. I don't want to worry you, but you will want to take your *Merck Manual* and *PDR* and medical dictionary with you. *They could save your life.* Remember how many patients die in hospitals because of medical errors. Don't contribute to that frightening statistic.

Be sure you know your diagnosis and whether it's tentative or firm. And ask what your drugs are. Look them up in the *PDR*. At the very least, the presence of the books at your bedside will alert the health professionals that you're involved and are watching them. Be sure the titles are visible because the *Merck Manual* and the *PDR* are very familiar to health care workers. They'll know you're *not* getting your information from John Smith's Handy-Dandy Manual. Some exhausted intern may follow your lead and use the *PDR* at the nurses' station to double-check for adverse interactions between the drugs he or she may be prescribing.

All too often, in hospitals and nursing homes patients receive drugs that are potentially hazardous, that may adversely interact, or that may be contraindicated. The overuse of psychoactive drugs in nursing homes is a particular problem. There even more than at home, patients board the merry-go-round of one psychoactive drug following another and another, each causing side effects, so it's the side effects more than the patients that are being treated.

According to Dr. Sidney Wolfe, director of the Public Citizen Health Research Group, 70 percent of doctors treating Medicare patients failed an examination on their knowledge of prescribing drugs for older adults (the majority of physicians refused even to take the exam, some stating that they had a lack of interest in the subject); 48 percent of patients taking three or more drugs received drugs that had one or more harmful interactions with other drugs. Each year drug reactions put 659,000 older adults in the hospital, and drugs induce or worsen memory loss in 163,000 seniors annually. Every year adverse drug reactions lead to over 30,000 falls and hip fractures in seniors, many of which are eventually fatal.

Not that I'm against drugs. They're an important part of my stock-in-trade as a physician. And one reason I'm still around to plunk away on the keyboard of my computer may be because I take a cholesterol-

lowering drug and aspirin as part of an overall plan for cardiovascular and general health. I'll discuss this in Chapter 3.

There's a word physicians use, *compliance*, that means how well the patient follows directions for taking his or her medications. I've learned as a geezer that missing dosages or taking a dose twice is not deliberate and does not show a lack of respect for the physician's recommendation, rebelliousness, or anything more sinister than challenges with memory. I frankly need my compartmentalized week's-supply pillbox. It's hard to keep several drugs straight. But it's important. For example, not remembering to take your antihypertensive medication could lead to a rebound, and your blood pressure could shoot up to a dangerous level. If you discontinue a blood pressure drug, as with the statins, taper the dose gradually under your doctor's direction. If you're taking Coumadin because you have atrial fibrillation or you've had a stroke or a TIA (transient ischemic attack, also called strokelet), don't stop the medicine without strict medical supervision. You could be risking another stroke or TIA.

In each chapter and section that follows, specific considerations regarding the use and misuse of drugs will be discussed where indicated.

RESOURCES

Three books you must have are:

1. *Merck Manual of Medical Information*
2. *PDR Family Guide to Prescription Drugs*
3. A medical dictionary (*Random House Health and Medicine Dictionary*)

If your bookstore doesn't have these books, you can order them through the Web sites amazon.com or bn.com (Barnes & Noble) and receive them quite promptly.

Wherever possible, I will supply postal addresses, phone numbers, and Internet addresses of resources that could be as up-to-date as your daily newspaper.

The National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20892
301-496-3000
www.nih.gov

U.S. Food and Drug Administration
Office of Consumer Affairs Inquiry Information
301-827-4420
www.fda.gov

Social Security Administration (SSA)—You should work with your local SSA office and State Health Insurance Assistance Program. If you have trouble finding these numbers call 1-800-772-1213 or use their Web site for general information: www.ssa.gov.

Medicare
1-800-MEDICARE (1-800-633-4227)
www.medicare.gov

AARP booklet D17195 on what to do if your Medicare HMO plan leaves: 1-877-276-5950

Web sites for information on health and medicine:

www.healthscout.com (rates the accuracy and value of health Web sites)

www.chid.gov (Combined Health Information Database); a good search engine

www.mayohealth.org (a top site for patients of all ages)

www.cdc.gov (public health and prevention)

www.fda.gov/medwatch/safety.htm (latest drug safety information)

www.webMD.com

(See disease- and condition-specific Web sites in the chapters that follow.)

The books I promised for potential activists:

Bleeding the Patient by D. Himmelstein, MD, and S. Woolhandler, MD

Healthcare Meltdown by B. LeBow, MD

Other sites useful for seniors

www.aoa.dhhs.gov/aoa/webres/craig.htm (Administration on Aging directory of Web sites)

www.aarp.org (American Association of Retired Persons)

www.ncoa.org (National Council on the Aging, a watchdog service)

www.seniorlaw.com (SeniorLaw—information relevant for seniors)