Medicine and the Media

The hair on the back of my neck stands up and I get an acid stomach when I watch the new ads on television for pharmaceutical products. There are three phrases that make me crazy. The first is, “Nothing is better than (insert drug).” What does this really mean? It could also mean that nothing is worse, but it usually means that all the drugs in this category are of the same potency, often even the same chemical compound. A bombastic statement of this kind influences public opinion and buying habits but really has little meaning.

The second phrase that bothers me is, “It has been clinically proven.” Never are there any data provided to back up this claim, but the phrase sounds very good. I propose that this phrase never be used in an advertisement without attribution to the clinical proof in a refereed medical journal or other scientific forum.

The third irksome phrase is, “There has been a medical breakthrough.” This phrase usually means one of two things. Often physicians have been aware of the facts reported for years, but the real breakthrough occurred when the media finally discovered the facts. Alternatively, the “breakthrough” has been made only in animals and no human testing has yet to be done. Never does the press retract the contention that there was a breakthrough when, years later, the drug or procedure doesn’t work in people. Often, the media do not even remember the initial report.

At least recently, the television advertisements have told the public which conditions to ask their doctor about. Initially, when prescription drug advertisements appeared on television, you were instructed to ask your doctor about (insert drug) but not informed of the indications for its use. Many patients called their doctors, asked about the drug, but did not have the disease for which the drug was used. This was a tremendous waste of physicians’ time.

Medical journals are not immune from these influences. Many journals follow the lead of the New England Journal of Medicine and the Journal of the American Medical Association and either provide press releases explaining what will be published in each issue or forward the issue to the press electronically or by fax. CHEST also provides press releases for two articles in each issue. I have had mixed feelings about this practice, although press coverage of the cough supplement and the whimsical chicken soup publication were accurate and beneficial to the journal.

On the other hand, there has been some problem with “spin.” Without identifying the publication or the press involved, let me try to identify the problem. I have believed for years that the press and public have no clue about the practice of intensive care medicine. Specifically, the issues of rapid invasive treatment, do-not-resuscitate orders, cardiopulmonary resuscitation, euthanasia, etc, can be inflammatory without the proper background and experience on the part of the reporter or the lay public. I have not selected such articles for press releases for that reason.

Recently, one study from a respected institution was included in our press releases. Autopsy results from a selected group of ICU patients were compared to clinical diagnoses made before death. From my own experience as a medical ICU attending, I know that in the year 2001, autopsies are sought in cases where the diagnosis was not obvious, i.e., the difficult cases. When the diagnosis is already proven, there is little need to do an autopsy. The cases in this report were therefore highly selected.

As I did the math, the autopsy results would have changed the treatment in only 8.8% of the autopsies that were reported. In addition, only 22.7% of the total of medical ICU patients who died underwent autopsy. While one doesn’t wish to miss any diagnoses, this small number was reported to help in future diagnoses and reflects excellent care.

The spin in the press was otherwise. “How could diagnoses be missed in such a prestigious clinic?” was the gist of the report. Lord knows, only malpractice lawyers are perfect because they have years to analyze the events that take place in seconds in the ICU. I thought that the press treated this report and this institution poorly and wished to bring this issue before the readers. I now review all press releases personally and will not allow an ICU-related press
Captaining the Ship During a Storm

Who Should Care for the Critically Ill?

By the middle of the last century, new therapeutic modalities in both medicine and surgery allowed patients who would have otherwise died to survive their diseases. These patients often needed more intense care than that provided on the wards of hospitals. In various medical centers, specialized units opened to care for these critically ill patients. The close monitoring of physiologic variables was possible with advances in technology, and the ratio of nurses to patients was increased. Critical care medicine was born.

Controversy exists regarding who should take responsibility for the care of the critically ill patients. Traditionally, in the United States, the attending physician with the aid of consultants (ie, intensivists and other specialists) have managed critically ill patients. In a large analysis published in 1992, only 22% of the ICUs in the United States were considered “closed” (ie, only the unit staff could write orders).

The arguments against ICUs being run by intensivists include the following: the relative youth of the specialty; the different training backgrounds and certification systems (eg, internists, surgeons, anesthesiologists, and pediatricians); and conflicts regarding patient management, reimbursement for care while the patient is in the ICU, and elevated costs in the ICUs. Unfortunately, most of the resistance comes from fellow health-care practitioners, who simply disagree that the trained, practiced, and committed critical care physician is the best physician to treat critically ill patients.

Despite fervor opposition by some, there is clear evidence that ICUs in which a physician or a team of physicians provides 24-h coverage have better clinical outcomes, better resource utilization, and enhanced teaching for housestaff, nurses, and associate health-care workers than those ICUs that do not.

An emerging body of data recently has arisen showing the benefits of having intensivists run ICUs. Much of this data has been collected in institutions that move from an open system to a system in which an intensivist provides coverage 24 h a day. This change has allowed the unique opportunity to compare the two systems during similar time periods, eliminating technologic or therapeutic variability.

Many of the studies were performed in medical ICUs. Brown and Sullivan reported a 52% reduction in mortality when comparing patients with equivalent APACHE (acute physiology and chronic health evaluation) II scores in 2 consecutive years. The primary attending physician treated the first group (mortality rate, 27.8%), and the second group was cared for by an intensivist in cooperation with the primary physician (mortality rate, 13.4%). Similar results were achieved in a study looking at the impact of critical care staffing on patients with septic shock. Despite similar APACHE scores, mortality was significantly lower after the introduction of physicians with critical care training. The authors also noted a decrease in nonsurvivors’ charges from 62 to 49%, probably reflecting a better resource utilization in hopefully ill patients.

Carlson et al reported results after a change from an open ICU, in which the primary care physician was in charge of the patient and the intensivist acted as consultant, to a closed ICU, in which critical care physicians directed the patient care. Despite higher APACHE II scores in the group treated in the closed system, improvement in clinical outcome was demonstrated by a lower ratio of actual to predicted mortalities. Although the housestaff indicated that they were busier in the closed system, they had higher levels of comfort in managing critically ill patients. Nurses, who provide most of the care for these patients, had a higher level of confidence in the intensivists when compared with the primary care physicians.

The introduction of a full-time director of critical care in a medical ICU of a community teaching hospital also resulted in a decrease in the overall mortality rate (from 20.9 to 14.9%). In this study, a detailed analysis of patients with pneumonia showed a reduction in the mortality rate from 46 to 31%. From an educational standpoint, residents improved their scores in the critical care in-training examination after the addition of the intensivist. Other studies have demonstrated reductions in the number of days patients require ventilators and in...