

## Crimes against humanity

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I AM A CLINICAL NEUROLOGIST. I'm not a health care economist or insurance policy expert. But, like most people, I have some moral code, and have read, with great anger, the various news reports of a handful of pharmaceutical companies destroying lives with price gouging.



I found the U.S. Senate's Special Committee on Aging's report on price gouging in the pharmaceutical industry (<https://www.aging.senate.gov/imo/media/doc/Drug%20Pricing%20Report.pdf>), summarizing some of the more outrageous behaviors I've read about before. This isn't the routine sort of price gouging that has been the norm, where Americans are charged double or more than Canadians or Europeans, or the collusion that characterizes the otherwise peculiar paradox where the development of more drugs to treat multiple sclerosis increases rather than decreases their price, despite the development of generics, and the increased competition.

The Report focuses on only four companies, noting that three of them had been newly taken over by hedge funds, which had no experience with pharmaceutical companies or, apparently, with normal human values. The report opines that the funds were responding to their investors, although one assumes that

the hedge fund managers, who take a percentage of the cut, are the major "deciders" of what happens and the investors close their eyes to the carnage in order to not sully the enjoyment of their increasing bank accounts.

The following characteristics are shared by the economic model: each

drug was the "gold standard" treatment for a particular disorder, reducing the competition; the market was small, making it unlikely that a competing company would emerge or that the affected population would be able to mount a significant opposition; distribution of the drug was closed, that is, a designated distribution company was used, rather than general pharmacies, again, reducing competition; and, finally, price gouging.

The price gouging is impressive. Daraprim's price increased from \$13.50 to \$750 per tablet; Thiola went from \$1.50 to \$30.00 per tablet; Seromycin, a drug for multiple drug-resistant tuberculosis, an increasingly worrisome scourge for the whole world, particularly the poorer parts, went from \$500/30 days to \$10,800; Valeant, the only actual drug company among the four targeted by this report, increased the price of two drugs for Wilson's disease, one of the rare, treatable neurodegenerative disorders, from \$500/30 days to \$24,000.

And, in case you think there have been typos with the number of zeros, you are mistaken. To top it off, all the drugs were available before 1990, some in the 1950s and '60s.

The Senate report indicates that the investors were fully aware of the business model and approved it. I am unsure if they would endorse the famous line of Gordon Gecko, in the movie, *Wall Street*, "Greed is good." My guess is that they would not have used the word "greed," and they would simply have said they were doing their job for their family, making them financially more secure. I doubt they actually took pleasure in thinking about the patients who would no longer be able to treat their disorders, about a 20-year-old girl whose liver and brain are failing, making her unable to care for herself, and, perhaps, ultimately, a ward of the state. I doubt they think about the implications of not treating multidrug-resistant TB for the whole world, including, perhaps their children.

The question is not why they do it. Bad, immoral people are part of humanity. The question is what can we do about it? It would be nice to post some photos in the post office, or in the local newspaper. One of the principal actors for two of the companies, Martin Skrelli, actually appears to enjoy the attention, apparently feeling, like book publishers, that a bad review is better than no review. The Senate committee's report was a great first step. It recommended

further steps, of course. It felt that anti-trust laws were unlikely to be helpful, that price transparency would be extremely helpful, but unlikely without legislation and that coupons and cost sharing with the company would be counterproductive, increasing costs for insurers and increasing the amount of drug prescribed. Most helpful, I think, would be their recommendation to allow temporary imports of the drug from other countries. I am pleased to note that since I wrote the first draft of this that Valeant has been devastated by a number of revelations, causing a dramatic drop in its value. I am unsure of the fate of the other companies, but

recent newspaper reports indicate that other investment groups have found this business model appealing and hope to cash in on our patients' misery.

We must keep in mind that what these four companies are doing is not much different than what we've recently seen with EpiPens, Narcan injections and newer forms of insulin. Drug companies are supposed to make money; however, they also have some responsibility to their clients, perhaps not a lot, but some. They are bullies without a moral conscience. I am not a believer in violence and abhor the death penalty, but crimes like these make me doubt my resolve. ❖

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## Workplace violence in hospitals and measures to address it

HERBERT RAKATANSKY, MD

**H**OSPITALS CAN BE DANGEROUS places and not only for patients.

The yearly incidence of physical abuse of nurses by patients is reported to be 30%. When asked about violence during their career, 61% of nurses who reported violent incidents indicated patients as the aggressors



(families and others also were perpetrators). Drugs and alcohol were involved in 58% of the incidents. Emergency room nurses were most at risk.

Can we predict which patients are potentially violent?

That is not easy. Persons in police custody are prime candidates. In the 11 years ending 2011, there were 154 “shootings with injury” on US hospital grounds. Twenty-nine percent of shootings in the ER were by patients in police custody, a number of whom were violent while trying to escape. Patients with delirium, alcohol or drug intoxication and psychotic behavior are prone to violent behavior. Patients, friends and families stressed by bad news, long waits and other frustrations may act out their anger.

The Occupational Safety and Health Administration (OSHA) reports that in 2014 there were 8 cases per 10,000 health care employees with violent injuries (80% inflicted by patients) serious enough to require time away from

work. The rate in private industry was less than 2 cases per 10,000.

In addition to being dangerous, workplace violence is expensive. In one hospital system 30 injured nurses (in one year) incurred expenses of \$94,156 (\$78,924 for treatment and \$15,232 for lost wages). The cost of replac-

ing a nurse can range up to \$100,000.

The number of violent acts against health care workers (HCW) is elusive. First, there is a lack of a standard definition of violence. Nurses and doctors report less than 30% of the violent incidents suffered and many health care workers assume that these incidents are “part of the job.” Interestingly, urban and suburban hospitals did not vary in the rate of violent incidents, though “high volume ERs and residential and day social services present the highest risk.”

There is a reluctance to report due to the feeling that the hospital administration disapproves of such reports and may look adversely at HCWs who make such reports. The new emphasis on “customer satisfaction” is also a deterrent to reporting. The business maxim that the “customer is always right” has become prevalent in the medical enterprise, but is harmful in these cases.

A rapid response by security officers when a violent act seems imminent or has happened is standard practice. But

this deprives other areas of the hospital of security protection. Security officers called to cope with an urgent situation will not be able to protect the parking lot, for example. The most frequent site of shootings (41%) in hospitals is on the grounds outside the building.

Violence impinges on patient care in number of ways. Medical personnel may be reluctant to care for potentially violent patients, thus decreasing the care available to these patients. And post-violence psychological trauma may impair the ability of HCWs to care for all patients.

So what can be done?

First, health care facilities should prohibit all firearms from their premises, except those carried by law enforcement. Metal detectors, however, are not in general use due to the many entrances to hospitals, high volume of persons and the cost of staffing.

OSHA has detailed guidelines about violence in the healthcare setting. They emphasize three steps: 1. Prevention (transfer patient to a safe environment, verbal de-escalation, etc.); 2. Work place adaptations (panic buttons, site specific issues such as accessible exit routes, etc.) and 3. Root cause analyses of all incidents.

Education of all HCWs in techniques of de-escalation should be universal. Verbal techniques to lessen the potential for violence may be effective. But training in self-defense may also be reasonable. The American Association for Emergency Psychiatry has a protocol for

such interventions. One RI health care system has initial mandatory training for nurses, PAs, etc. but not for doctors. Annual refresher training (best practice standard) is not offered due to lack of resources.

Simple approaches such as having security personnel wear clothing that is not the typical police uniform can avoid triggering violence in some persons (such as gang members, patients with criminal background, etc.) who react negatively to police. Uniformed security officers, however, are more effective in other situations, so this approach is possible only in units with dedicated security personnel.

Most states, including RI, classify assaults on HCWs as felonies. Assault means an action intended to cause bodily harm (even if no harm results). In RI “any person” who “knowingly and willfully” assaults a “health care provider” during treatment may be “imprisoned for up to 3 years and fined

not more than \$1500.” While this law is not likely to deter a patient in the throes of delirium, it may be a deterrent to others.

Verbal and low level physical abuses are precursors to physical violence. A “zero tolerance” for all abusive behavior, no matter how minor, with appropriate interventions designed to de-escalate the situation may prevent major episodes of violence. This approach means reporting of all such behavior to the institution. Most importantly, the staff must have confidence that the institution truly believes in this approach and is fully committed to react promptly.

After a violent incident occurs it is critical that the staff have prompt therapeutic interventions to assist in coping with the stress. Trained “trauma-informed” teams with special expertise offering personalized treatment are already in place in many RI hospitals and are important to the health of the victims.

In situations where violent patients

require prolonged care, transfer to a specialized unit may be the best option. Just as cases with massive injury are best treated in a level 1 trauma center, violent behavior, not responsive to initial intervention, may be best treated in a unit with expertise and resources in the many facets of this behavior. Unfortunately, such units may not be readily available.

One hospital system (822 beds) reported 42 workplace violent incidents in 2012. After adopting a comprehensive approach to workplace violence there were 19 incidents yearly in 2015 and 2016.

These approaches work. Our patients and staff deserve no less. ❖

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