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## Doctors falling down on the job

JOSEPH H. FRIEDMAN, MD  
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I RECENTLY WAS WAITING in the parking lot of a supermarket just outside a large retirement community, and watched people walk. It provided an amazing display of senile gait disorders. Over the ten minutes there I found that the majority of people walked abnormally, and these were elderly people who had driven to the market. I wished that I had had my video camera and a tripod, and decided that my smart phone, although adequate, was sub-optimal and that the issue of informed consent would be problematic.

Falls are a major public health problem for the elderly. The numbers for incidence, morbidity, mortality and cost are staggering. One third of people over the age of 65 fall each year and only half tell their doctors. Twenty percent of these falls result in a serious injury, so that over 700,000 people are hospitalized each year due to a fall. Over 2.5 million elderly are treated in a hospital emergency department, and over a quarter of a million older people require hip surgery due to falls. The direct costs of falls (not counting the financial losses to family and friends, or to the patient, if still working) are over 34 billion dollars each year. Since falling once doubles the chances of falling again, it obviously makes sense for doctors to ask about falls in order to reduce



the risk of another. To increase the likelihood that this occurs, doctors are mandated by Medicare to explicitly ask anyone over 65 if they've fallen in the past year. They are penalized if they don't document this in the chart. However, the rules do not require that anything be done about

it. There is no requirement to assess gait or refer to someone who might be expert in gait evaluation. Or to simply refer for physical therapy.

Yet it's a rare primary care doctor, or any other doctor, for that matter, who pays attention to this, in the sense of trying to *prevent* the first fall. In a recent study at a major, top-flight American university medical center, in which charts were reviewed to see how cancer specialists evaluated elder cancer patients who had fallen. Only 10% had their falls documented and only 20% had their gait assessed. This is, of course, a population at high risk for complications from falls. This is about the same as occurs in primary care practices as well. Of course, specialists, like oncologists, probably assume that gait is a primary care concern.

I asked 25 older family members or friends of patients I was evaluating whether their primary care doctor had ever watched them walk as part of their exam. Only one could recall this

happening. A new patient, a retired elderly physician, saw me recently to evaluate his walking problem. He noted that he made the appointment after he heard me give a talk on gait abnormalities in the elderly and how primary care doctors rarely evaluated walking. My patient told me that he extended my informal study to include his assisted living center, where everyone was over 65, and found that none of the patients had been watched walking by their PCP.

The causes of falls are multitudinous, and may involve one or more of the many systems that give us mobility. These span the body from the toes, with arthritis, deformities, ulcers, neuropathy to the top of the brain, with a variety of brain disorders. In between are disorders of skin, joints, bones, muscles, nerves, spinal cord, inner ear, vision, brain and psyche.

Most gait problems are probably not fixable, but some are. Physical, balance and vestibular therapy may be quite effective in reducing fall rates, and some gait problems may be improved dramatically, as sometimes occurs in people who are diagnosed with Parkinson's disease when placed on

**A new patient, a retired elderly physician, saw me recently to evaluate his walking problem. He noted that he made the appointment after he heard me give a talk on gait abnormalities in the elderly and how primary care doctors rarely evaluated walking.**

appropriate medications.

Many improve miraculously when certain medications are stopped. Learning to use an assistive device such as a cane or walker, rather than avoiding it, can save hips and nursing home placement.

The most basic principle of prevention is prevention. It is best done *before* the first fall, although gait assessment at any time is better than ignoring it

all the time. In the elderly a “routine” examination is more likely to turn up a gait abnormality than it is to reveal a new heart, lung or abdominal problem. PCP’s need to evaluate gait in the elderly as part of their routine examination. As Yogi said, “You can see a lot just by looking.” The goal is to identify the problem as existing, not necessarily diagnosing the cause, and then figure out how to reduce the risk of a fall. ❖

### Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal*, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, chief of Butler Hospital’s Movement Disorders Program and first recipient of the Stanley Aronson Chair in Neurodegenerative Disorders.

### Disclosures on website

## Erratum

R I Med J (2013). 2017 Apr 3;100(4):33-36.

**ERRATUM:** Unexpected Serious Cardiac Arrhythmias in the Setting of Loperamide Abuse.

Rasla S<sup>1</sup>, St Amand A<sup>2</sup>, Garas MK<sup>3</sup>, El Meligy A<sup>1</sup>, Minami T<sup>4</sup>

**Corrected to:** (Authors added: <sup>2,3,6</sup>)

Rasla S<sup>1</sup>, Parikh P<sup>2</sup>, Hoffmeister P<sup>3</sup>, St Amand A<sup>4</sup>, Garas MK<sup>5</sup>, El Meligy A<sup>1</sup>, Minami T<sup>6</sup>, Shah NR<sup>3</sup>

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**PUBLISHED ERRATUM:** R I Med J (2013). 2017 Aug 1;100(8):5.

**Abstract:** Loperamide (Imodium) is a non-prescription opioid receptor agonist available over-the-counter for the treatment of diarrhea. When ingested in excessive doses, loperamide can penetrate the blood-brain barrier and is reported to produce euphoria, central nervous system and respiratory depression, and cardiotoxicity. There is an emerging trend in its use among drug abusers for its euphoric effects or for self-treatment of opioid withdrawal. We report a case of ventricular dysrhythmias associated with loperamide abuse in a 28-year-old man who substituted loperamide for the opioids that he used to abuse. [Full article available at <http://rimed.org/rimedicaljournal-2017-04.asp>, free with no login].

**Keywords:** Arrhythmias; Loperamide; QTc prolongation; Ventricular tachycardia; opioid abuse

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## The Core of Medical Ethics

HERBERT RAKATANSKY, MD

I WAS TAUGHT IN MEDICAL school that rich or poor, law abiding or criminal, all ill persons should receive treatment.

Our country is in the midst of a heated debate about the degree to which government should regulate and finance our health-care system. If government defines the relationship of its citizens to the health-care system, governmental values would determine who gets care.

But physicians have intrinsic ethical obligations that transcend the standards imposed by government and other belief systems.

In some countries the values of a specific religion or political system define the values of the health-care system. And these values may clash with the ethical responsibilities of physicians.

For example, physicians recognize informed consent as a fundamental ethical value rather than a policy subject to governmental policy that might change.

In the United States (US), our profession's moral guidelines are codified in the AMA Code of Medical Ethics, a uniquely physician-developed, broad-based set of ethical standards for our profession. Other ethics' guidelines authored by professional medical organizations also set standards.

The "Principles of Medical Ethics," the bedrock of the AMA Code, clearly states



the core ethical value: "A physician shall support access to medical care for all persons." Ignoring this imperative puts us on a very slippery slope.

With a few exceptions ("do no harm" espoused by Hippocrates), medical ethics as an independent value system is a recent development. The stan-

dards of professional medical behavior in the 19th century generally were codes of etiquette for doctors, rather than values designed to protect patients. Even the first AMA Code (1847) was of this vein.

At the bottom of the slippery slope lie perverted governmental values that became legal medical ethical standards during the Nazi regime (1933–1945).

Interestingly, in 1931 the German government (not the German medical profession) issued "guidelines for human experiments and therapy" that included informed consent and protection of vulnerable populations. Those who believed in eugenics, forced sterilization, etc. received no governmental support. When Hitler came to power in 1933 everything changed.

The Nazi view of humanity considered the entire German population as one organism (the "Volk"). The Volk was defined as white and Aryan. Jews, gypsies, disabled and chronically

ill people and other minorities were considered to be diseased parts of the whole organism. Nazi law required reporting of persons with hereditary disease. Elimination of all non-Aryans by forced sterilization and extermination were judged by the government to be therapeutic for the Volk and therefore ethical. This belief infected the German medical community and was taught in all German medical schools as part of a standardized national ethics course. There was little if any resistance by the German medical establishment.

In fact, Dr. Rudolph Ramm, a dedicated

**The "Principles of Medical Ethics," the bedrock of the AMA Code, clearly states the core ethical value: "A physician shall support access to medical care for all persons." Ignoring this imperative puts us on a very slippery slope.**

Nazi anti-Semite, wrote a textbook of ethics reflecting this viewpoint. Ramm's book emphasized informed consent, the right to a consultation and the use of specialists when appropriate, but only for pure Aryans. And he endorsed the 1931 guidelines, but only for Aryans. The book was a best seller and was reprinted several times. Dr. Ramm was captured, tried and executed by the Soviets in 1945. Twenty-three Nazi doctors used this viewpoint as a defense during their trial in Nuremberg in 1946–1947. Sixteen were convicted. Seven were executed.

Also, consider the German doctors

who developed and prescribed Pervitin, an amphetamine, to German troops *en masse*. Did you ever wonder how the blitzkriegs that overran Western Europe so rapidly were accomplished? The German troops were able to stay awake and fight for three days continuously because they were on drugs (chemical warfare in reverse).

There are other examples of societal and governmental values influencing and sometimes defining medical ethics. Stalinist Russia considered political dissidents to be mentally ill, and Soviet psychiatrists committed them to hospitals.

Closer to home, consider the doctors who have participated in executions and state-sponsored torture. Their victims were not offered the opportunity to give informed consent. (They certainly would have refused.) Forced sterilization of “misfits” by doctors in the US started in 1907 in Indiana and persisted until 1981 in Oregon. The indigent black subjects of the Tuskegee experiments were denied penicillin when it was proven effective. These prisoners, torture victims, “misfits” with hereditary and

other “defects” and experimental participants were considered to be inferior parts of our society, not worthy of the protections contemporary medical ethics afforded to others (sound familiar?).

Governmental policies may, *de facto*, withhold medical care from some groups. The primary mechanism is financial. The vast majority of patients who do not get treatment do not get it because they cannot afford it; 11.2% of the non-elderly were uninsured in 2015; 45% were white, 32% were Hispanic and 15% were black. Policies that perpetuate poverty, discrimination and lack of literacy create groups of people without access to health.

Bias in the political arena (based on race, gender, sexual orientation or identification and other issues) may influence health care. For example: the Senate task force to rewrite the health-care law has no women members. This is a political issue but, since it may affect the medical care of women, it also is a medical issue.

Another example: In 2010, Medicaid financed 48% of all births in the US. That figure is likely higher now. If

legislation narrows Medicaid coverage, the group of women with no health-care coverage during their child-bearing years will enlarge. And this will happen in a country with the highest maternal death rate in the developed world.

Governmental creation of groups of persons who, as a result of focused policies, or *de facto* as a consequence of other policies, are denied medical care is an ethical issue for doctors today, as it has been historically.

It is critical that we practice medicine in concert with our own professional ethics’ standards, not those imposed by third parties, especially the government. This requires not only diligence when treating individuals but also active involvement of individuals and medical organizations in the democratic process when policies (current or proposed) designate specific groups of persons who are or will be denied medical care. ❖

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## Kilmartin's castigation of physicians, medical society regarding warrantless searches into PDMP demeans AG's office

*Editor's note: Excerpts of the following Letter to the Editor from Dr. Michael E. Migliori appeared in the Providence Journal recently.*

To the Editor:

I read with disgust Attorney General Peter F. Kilmartin's comments about the Rhode Island Medical Society's objection to the bill [now signed into law] that would allow warrantless searches in the Prescription Drug Monitoring Program (PDMP), calling us disingenuous and liars, and suggesting doctors have something to hide. He further stated in an article in the Providence Journal that "Doctors helped create the opioid problem; now they need to be part of the solution and support this bill."

<http://www.providencejournal.com/news/20170717/advocates-urge-veto-of-bill-to-open-prescription-drug-database-for-law-enforcement>

The AG is tacitly saying that all physicians are criminal; he just hasn't caught them yet. That would justify violating protections from unwarranted searches. His attack on physicians and the medical society is demeaning and personally insulting. I am a past president of the medical society and have been chair of its legislative committee for close to 17 years. Just about any legislator can tell you that the vast majority of what we do at the State House is for the benefit of our patients, including keeping the government out of the exam room and protecting patients' privacy. Our opposition to this legislation is no exception.

Doctors and other prescribers do share some responsibility for making

narcotics easily available. Up until a few years ago, medical providers were being penalized for not doing enough to alleviate pain. Because of pressure by the federal government, insurers, and state legislatures to address pain, physicians, in retrospect, did overprescribe. As the opioid epidemic has grown, however, RI prescribers have stepped up and reduced the amount of narcotic prescriptions by 24%, the second highest reduction in the country. The Rhode Island Medical Society worked with the Department of Health to craft the PDMP to give prescribers a tool to see if patients were getting controlled substance prescriptions filled elsewhere, and continues to work with the General Assembly to create programs that educate prescribers on safe prescribing and reducing drug diversion. As a result of the reduction in prescription drugs being diverted in RI, opioid users are turning to illicit narcotics. The vast majority of overdose deaths in this state are from illicit drugs, especially drugs laced with Fentanyl. So even with the reduction in medical provider contribution to the problem, we don't have a corresponding reduction in the demand, and that is the sad part.

Rhode Island's medical providers have already become "part of the solution" and done more than most to reduce the availability of prescription narcotics. What hasn't been done is the hard work of reducing demand. This requires infrastructure, destigmatization of addiction, alternatives to incarceration, mental health services, and, most importantly, money. When addicts cannot get prescription drugs, they get illicit drugs, and

they die from that, but our leaders won't tackle that because it costs too much. They pat themselves on the back because they've done something meaningless while Rome burns.

The AG thinks that we can solve the opioid crisis by passing laws that target prescribers and violates privacy. Allowing access to private medical information in the PDMP (which includes not only the identity of the doctor prescribing the medication but also the name, address, and the narcotic, anti-anxiety, ADHD, and every other controlled substance prescription history of patients) without a judicial review is wrong. The so-called protections in this bill make the Director of Health the judge, which is not fair to the Director, physicians, or patients. The Director already has access to the database, and knows who is prescribing what. She already has power to sanction abusers. I see no reason that we should allow anyone else to bypass judicial review to access sensitive and confidential information.

AG Kilmartin, I take personal offense at your characterization of physicians and the Rhode Island Medical Society. I know what we stand for and why we protect our patients. We may disagree with each other on the merits of this bill, but for you to publicly castigate us as liars and criminals is beneath the dignity of your office.

Michael E. Migliori, MD, FACS  
*Past President  
 Chair, Public Laws Committee  
 Rhode Island Medical Society  
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## “3 Good Things” in Recovery

SAMUEL M. MILLER, ScB; ROHAN KATIPALLY, ScB

“HOW DO I KNOW YOU'RE NOT GOING to use again?” a woman reads in a text message from her 14-year-old daughter. The woman struggles with her daughter still worrying about her relapsing one day, erasing the goodwill accumulated from ten years of being clean. “Ugh, kids are just so smart these days!” she says with a smile.

Recovery is a difficult process that involves not only the individual but also family and friends. Further complicating addiction is the co-existence of mental health illness. Nationally, 48% of people suffering from heroin addiction also suffer from depression.<sup>1</sup> To address the difficulty that mental illness poses to those in recovery, we piloted a mindfulness and positive-psychology intervention titled “3 Good Things” as part of a medical school course in population health. Participants were asked to write three good things that happened to them every week and to describe how each made them feel. These “three good things” were then discussed with a counselor on a monthly basis. Originally studied by Seligman et al. in 2005, this intervention was found to lessen depressive symptoms and improve happiness in a general population.<sup>2</sup> We hoped to find similar results with methadone patients at the Discovery House in Woonsocket, RI. Discovery House provides outpatient treatment and counseling for a variety of addictions with the primary goal of promoting holistic recovery.

We were drawn to an intervention that would not only address mental health but also operate within the context of recovery as a process. “3 Good Things” could be done in any setting at any time, making it both a realistic and flexible intervention. Furthermore, the focus on positivity is an especially useful counseling paradigm as it relies on positive self-reflection more than just remembering good things that have happened recently. We partnered with the Discovery House specifically because of its strong counseling program. These counselors, who have established longitudinal relationships with their clients, were able to facilitate reflection on the significance of these journal entries and ultimately, solidify the impact of this intervention.

After meeting with Dr. Andrew Stone, the medical director, and Jennifer Camp, clinical services supervisor, we began the intervention at Discovery House in October 2016. On a weekly basis for twelve weeks, participants completed the “3 Good Things” journaling. During their monthly counseling sessions, patients would review their entries with their counselors.

After three months, we met with the counselors and patients to gather feedback. This program appeared to benefit participants in various ways, some of which we did not entirely expect. By structuring enrollment and check-ins with counselors as the primary point of contact, discussion of journal entries

and gratitude served to enrich the patient-counselor relationship. Especially for new patients at Discovery House, this helped engender that initial connection. Furthermore, counselors noticed that journal entries helped their patients reflect on the “value of sobriety and family” and “appreciate the ‘now’.”

One patient’s mom decided to enter his life again after he began his recovery. Getting into his car reflexively triggers him to think about going to a friend’s home to use, but he took his entry about his mom being back in his life and wrote it on a post-it note on his dashboard. This helps him remember the tangible positives of being in recovery and how he doesn’t want to lose his relationship with his mother again.

Another woman wrote that she was “reminded of how grateful I am to be a mother of two daughters,” while another participant wrote, “It really opened my eyes and showed me how far I’ve come in the past five months of my recovery.”

The reflective nature of the intervention may help participants obtain improved insight regarding their moods, their paths to recovery, and how the choices they make affect that. Making the connection between positive experiences and a period of sobriety may also help combat the manifestation of mood disorders in recovery.

Moving forward, we plan to focus on patients who are just beginning their relationship with Discovery House.

Counselors believe that the intervention will be especially helpful for these patients as it will help to establish and strengthen the counselor-patient relationship. In addition, we will suggest making three journal entries weekly for four weeks as opposed to the weekly entries for twelve weeks. We imagine this more condensed exposure will help new patients to acclimate to Discovery House and give them more to talk about at their first few counseling sessions. We also hope that the shorter intervention will be easier for patients to complete.

Some challenges we faced were more intrinsic to positive psychology in general. During one of the group sessions, a patient asked, "What if I don't have any good things to talk about?" This was an important question for us to consider because it encapsulated the purpose of the intervention itself. In many ways,

"3 Good Things" is not just about writing down happy thoughts, but also about trying to reflect optimistically and positively about life in general.

This intervention reminded us that recovery in opiate and other addictions is truly a multifactorial process, often complicated by coexisting depression or other mental illness. When counselors encourage patients to reflect on their experiences in positive ways, it not only enriches patient-counselor relationships, but also gives patients a cognitive tool-set to use when they are on their own.

As we begin our final year of medical school and ultimately our lives as physicians, we hope to continue to bring the practice of gratitude to our patients not only to promote physical healing but also to encourage emotional health and general happiness. ❖

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