LEADERSHIP PAGE

Seven Deadly Sins of Health Care
Part II

Kim Allan Williams, Sr, MD, FACC, ACC President

My last Leadership Page focused on 4 of the “7 deadly sins for public health”—greed, complacency, timidity, and obstinacy—developed by Harvey Fineberg, MD, PhD, during his time as president of the Institute of Medicine (1). Where Fineberg had focused on the “sins” and the broader public, I focused on ways these sins might also apply to the health care market, policymakers, and other public health stakeholders (2). In the final segment of this 2-part series, I want to focus on the 3 remaining sins: sloth, gluttony, and ignorance.

When we talk about sloth, we are talking not about the slow-moving animal that lives in trees in South and Central America, but rather about the state of inertia. From a public health perspective, inertia is what keeps some of our patients from making diet and exercise choices that would keep them healthy—placing them at increased risk for cardiovascular disease and other risk factors like hypertension, high cholesterol, and diabetes. It is also one of several factors that contribute to issues with medication adherence. Finding out where your patients are in terms of motivation and willingness to change their behavior is a key element to successful therapy, as is modeling good cardiovascular health habits for patients to see.

Inertia can also be at the root of complacency on the part of us as cardiovascular care providers, which according to Fineberg is the acceptance of things as “normal” that are actually “preventable or avoidable” (2). But, more commonly we are all working very hard, even risking burnout as we try, sometimes against all odds, to change outcomes for challenging patients.

The College continues to find ways to help patients and clinicians overcome health care inertia. CardioSmart, for example, has developed a series of free infographic posters and fact sheets focused on the benefits of active living and healthy lifestyle choices that can be used during conversations with patients help prevent or manage heart disease. Additionally, an online activity tracker helps to easily encourage patients and accurately follow their exercise accomplishments. From a provider perspective, the American College of Cardiology’s (ACC’s) NCDR (National Cardiovascular Data Registry) hospital and outpatient registries offer increasing opportunities to track adherence to guideline-based care. In some cases, these registries can also be used for streamlined participation in federal incentive programs, like the Physician Quality Reporting System and Meaningful Use program. Additionally, the ACC’s constantly growing suite of mobile applications are being designed to keep inertia at bay by putting guidelines and risk calculators quite literally at our fingertips.

Gluttony is another “sin” that can be applied at the most literal level to the broader public. Let us call this “overconsumption.” Developed nations like the United States are facing an obesity epidemic that is in large part due to overindulgence of food and drink combined with a paucity of exercise. Food choices affect this greatly, and surveys indicate that patients and physicians know very little about nutrition. For example, completely filling the average human stomach with vegetables would require consumption of about 400 calories. But 400 calories is only 6.7 ounces of steak (perhaps a one-third-full stomach), or 3.3 tablespoons of olive oil (about 1/20th full). A great number of people, especially in the United States, are taking in far more calories than they can burn off as...
a result of busy lifestyles that rely heavily on prepared foods, take out, or drive-through windows.

On a less literal level, however, overconsumption can also be characterized as an overindulgence in other things like wealth. Wealth by itself is not a bad thing, but the quest for wealth should not lead to decisions (or lack of decisions) that disregard science and/or harm public health. The cigarette industry and the recently released 2015 to 2020 Dietary Guidelines for Americans (3) are great examples. With the new guidelines came allegations that special interest groups had undue influence on the final recommendations, making headlines in major media sources. These guidelines, ironically, are to give the best available information on how people can change their overall eating patterns. In other cases, annual profit margins or executive staff salaries for payers, health systems, drug manufacturers, and so on have been blamed for high costs of drugs and denials of evidence-based procedures for patients, among other things. Some health care providers themselves are also guilty of overconsumption on rare occasions, and many of them are facing legal consequences.

How do we address this? Again, on the public level, the ACC’s CardioSmart website provides plenty of tips for healthy eating and activities. We have an active nutrition committee within our prevention committee that is dedicated to getting more nutrition information out to patients and education to physicians. The College’s chapter leaders and advocacy staff are also on the front lines pushing for funding for research and for state and national programs targeted at slowing the obesity epidemic. The ACC also continues to lead in the development of appropriate use criteria to help clinicians and payers determine the most appropriate care based on current evidence, thus making it harder to deny life-saving services. The ACC’s Payer Advocacy Team also works hard to address authorization issues and specific payer policies as they arise. As mentioned in the previous Leadership Page, the College is also on the cutting edge of quality improvement services for hospitals and institutions that are intended to help facilitate cultural changes and move away from simply focusing on financial gain (1).

Last, but certainly not least, is ignorance. Fineberg defines it best, noting that “ignorance, sometimes willful, colors judgment and leads to poor health decisions by both individuals and policymakers” (2). Let us call it “poor health literacy.” From a public perspective, poor understanding of risk factors, disease symptoms, treatment options, and even specifics about individual health care coverage can lead to worsening of a disease, uninformed decisions about care, delayed presentation for critical illness, or even avoidance of care all together. Willful avoidance—when patients are motivated by fear of bad news—can be devastating and generally worsens outcomes. Our ACC chapters have a variety of community initiatives that help raise the bar in terms of public education on heart disease. This is a gradual process, but must be continued and enhanced to lower both monetary and human costs.

Health care providers are not immune from the lack of timely information. Faced with a rapidly growing amount of information available with published studies, guidelines, and other clinical consensus documents from multiple sources via multiple channels, it can certainly be overwhelming to keep up or try to triage what information is most valuable. The same is true for policymakers who are inundated with information on a variety of topics—all of utmost importance to a particular constituent or constituency—and pressed for a decision or action. Failure to fully understand an issue can lead to a policy or program that is not beneficial to patient care and outcomes or very difficult to implement.

With the ACC’s mission to transform cardiovascular care and improve heart health, purposeful education is 1 of the key elements of our strategic plan. Providing patients with information is a vitally important role for CardioSmart.org, which serves as a 1-stop shop for everything patients need to understand cardiovascular disease and risk factors. Our new ACC.org continues to grow as the professional home to the cardiovascular care team, providing streamlined access to the latest news, clinical documents, treatment guidelines, expert commentaries, case studies, educational programming, quality improvement efforts, and more. The College is also committed to developing and using easy-to-use mobile tools and decision support aides that make resources like clinical guidelines usable at the point-of-care. A new pilot program that recently launched in China actually brings prevention and guideline tools directly to hospitals and physicians through focused webinars and use of WeChat—a widely popular social media forum in China.

Through its advocacy and quality improvement efforts, the ACC is also helping to ensure that policymakers, payers, and others partner with cardiovascular caregivers to improve patient outcomes. The ACC’s annual Legislative Conference brings more than 400 cardiovascular professionals to Washington, DC, each year with the goal of educating Congress about the strides we are making to ensure high-quality, cost-effective cardiovascular care. Advocacy also includes ACC leaders frequently being asked to
testify before Congress or regulatory agencies like the Centers for Medicare and Medicaid Services on topics like personalized medicine, value-based payment, use of registries, appropriate use criteria, electronic health record use, and more. Additionally, live meetings like the ACC’s Annual Scientific Session or Cardiovascular Summit provide unique opportunities for ACC members to hear from lawmakers, regulators, and other stakeholders about trends and issues facing the cardiovascular field as a result of the ongoing changes to the health care environment.

We continue to emphasize that the ACC does not exist for its own sake, but rather for the sake of its now 52,000 and growing members and their patients. Guidelines and appropriate use criteria, educational products and programs, member sections and chapters around the globe, the JACC journals, and health policy and advocacy efforts are all designed to help cardiovascular professionals deal head on with greed, sloth, gluttony, ignorance, complacency, timidity, and obstinacy, and ultimately provide the best care possible to patients. Together, we can strive to be the counterbalance to the 7 deadly sins of public health.

ADDRESS CORRESPONDENCE TO: Kim Allan Williams, Sr., MD, FACC, American College of Cardiology, 2400 N Street NW, Washington, DC 20037. E-mail: president@acc.org.

REFERENCES