

### Should we upend health care? Yes! (But how?)

In his guest editorial, “Upending this country’s approach to health care” (*J Fam Pract.* 2018;67:744-745), T. R. Reid makes a number of good points. However, I disagree with his opinion that “This disgraceful state of affairs is not the fault of the nation’s physicians. Rather, the problems with health care in the United States stem from the system that American providers have to work in.”

Through our choices, we have helped create this current system. I started as a family practice attending physician in 1994 and worked in 2 community hospitals. One of these hospitals closed its doors in 2012 and the other merged with a large health care system in 2015. During my 25 years of practice, I watched all of my outstanding primary care colleagues (family medicine, internal medicine, and pediatrics; 25 to 30 in total) stop their practice of combined outpatient and inpatient work. I currently do not see any primary care physicians (who do outpatient work) during my hospital patient care. Yes, it’s lonely.

I believe this significant change in practice across the United States has led to unintended consequences. First, the administrative burdens (and likely costs) for hospitals and health care systems have risen. Newborn, pediatric, and adult hospitalist services had to be built or bolstered, and then maintained, and the growing number of employed physicians had to be managed. Second, primary care’s attractiveness to some medical students has declined. Should students want a practice where they will likely never take care of their patients in the office and the hospital?

I agree we have a “disgraceful state of affairs,” and we need to work together for the tough solutions. However, as health care leaders, we must take responsibility for our roles in creating the current



system. We must acknowledge these roles and learn from them.

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As a longtime family medicine practitioner, I can’t agree more with Mr. Reid’s assessments of the state of our health care system. I have experienced health care from my practice as part of an HMO in Wisconsin, and in a hospital system in Raleigh, NC. Our

“system” has done such a poor job of allocating its resources and has sacrificed so much to generate profit for the insurance and pharmaceutical corporations. The question is: How do we develop the political will to overcome these deep pockets to change the system? Victor Fuch’s article in the November issue of *JAMA* makes a very compelling case for a national health plan.<sup>1</sup>

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### Another practice’s experiences in “dialing back opioids”

It is with much enthusiasm that we read the article “Dialing back opioids for chronic pain one conversation at a time” (*J Fam Pract.* 2018;67:753-757) about the author’s approach to opioid tapering. We have implemented a similar process in our own medical home practice, based on the continuity relationship and the Ecological Systems Theory.

The use of the human resources within the medical home—care coordinator, pharmacist, community health worker, etc—distributes the responsibility and lessens the burden of care for the family physician. The Ecological Systems Theory provides a structure for understanding the interaction between proximal influencers (eg, the team)

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➤ As health care leaders, we must take responsibility for our role in creating the current health care system.

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➤ Hypoglycemia in older T2DM patients often presents with atypical neurologic symptoms, including incoordination and ataxia, slurring of speech, and visual disturbances.

and more distal influences (eg, national guidelines and institutional mandates).

Recently, we presented our findings at the 2018 North American Primary Care Research Group (NAPCRG) Annual Meeting. Our results showed a 50% decline in per capita medication use over an almost 14-month period.

We feel that opioid tapering provides both a counterpoint and a complementary method to medication-assisted therapies (MAT). A counterpoint, because MAT involves the diagnosis and treatment of opioid misuse disorder. At the core of that diagnosis is the question of whether all chronic opioid use should be labelled as “misuse.” Tapering involves no such diagnosis and focuses on the safety of minimal opioid use, which, when MAT is used appropriately, is also a primary concern.

We appreciate the approach that the authors took in their project and look forward to seeing further iterations.

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**Hypoglycemia in the elderly: Watch for atypical symptoms**

We read with interest the review article by Keber and Fiebert, “Diabetes in the elderly: Matching meds to needs” (*J Fam Pract*. 2018;67:408-410,412-415). The authors have provided a timely overview of antidiabetes medications for elderly people with type 2 diabetes mellitus (T2DM) and their relative risks for hypoglycemia.

We’d like to add to this important conversation.

Aging, per se, modifies the glycemic thresholds for autonomic symptoms and cognitive impairment; in older nondiabetic

men (mean + SD: age 65 ± 3 years), autonomic symptoms and cognitive dysfunction commence at identical glycemic thresholds (3 ± 0.2 mmol/L [54 ± 4 mg/dL]). By contrast, in younger men (age 23 ± 2 years), a significant gap is observed between the glycemic threshold for symptom generation (3.6 mmol/L [65 mg/dL]) and the onset of cognitive dysfunction (2.6 mmol/L [47 mg/dL]).<sup>1,2</sup> The simultaneous occurrence of symptoms and cognitive impairment in older people may adversely affect their ability to recognize and treat hypoglycemia promptly.

In addition, hypoglycemia in older T2DM patients often presents with atypical neurologic symptoms, including incoordination and ataxia, slurring of speech, and visual disturbances, which either are not identified as hypoglycemia or are misdiagnosed as other medical disorders (eg, transient ischemic attack).<sup>3</sup> Knowledge about hypoglycemia symptoms is poor, in both elderly people with diabetes and their relatives and caregivers, which compromises the ability to identify hypoglycemia and provide effective treatment.<sup>4</sup> Education about the possible presentations of hypoglycemia and its effective treatment is essential for older patients and their relatives.

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