Healthcare “Practice”—Is it Misguided?

Ritu G. Grewal, M.D.

Pulmonary Division, Sleep Disorders Center, Thomas Jefferson University Hospital, Philadelphia, PA

It is with interest, dismay and frustration that I read Dr. Quan’s article “The Healthcare Debate—Is it Misguided?”¹ Dr. Quan talks about the two main issues facing the American Healthcare system. Are healthcare dollars being appropriately apportioned—“are we getting the best bang for our buck” and more importantly, the bigger issue of “accessibility.” At no point in his discussion, does he mention how we as a sleep community are standing by passively regarding these two issues. There are no ideas forthcoming from his editorial as to how the sleep community can contribute in a meaningful way to address these two issues.

Let me elaborate on how we as sleep specialists have and continue to contribute to this problem.

Sleep testing in the sleep lab is costly and has grown by leaps and bounds in the last 10 to 15 years. Part of the reason is the growing awareness of obstructive sleep apnea and its health consequences, along with rising obesity in the country, which has contributed to the increased incidence of this disorder. However, a big part is the enormous revenues generated by the technical component of a sleep study. Sleep labs have grown exponentially in this country. The technology for conducting the studies has not changed drastically in the last 10-15 years and neither have the medical indications to order a sleep study.² Polysomnogram (PSG) is useful mainly to diagnose and treat sleep apnea along with a handful of other disorders, all far less common than sleep apnea.

The AASM published a paper on guidelines for portable monitoring in 2007.³ This was in response to an impending resolution by CMS approving use of portable monitoring to diagnose sleep apnea. There has been little else since then, and for the most part sleep labs including mine have not embraced this technology. Even the guidelines recommended in that article have not been implemented in any meaningful way in clinical practice by most academic institutions. Ambulatory monitoring along with the use of auto-titrating CPAP is being used at the VA medical centers all over the country. Health care dollars are being apportioned appropriately at the VA Medical centers, and the veterans, I suspect have more “accessibility” to getting their sleep apnea diagnosed and treated than the millions of Americans who do not have health care; those that do cannot access it because of the out-

rageous copays and deductibles that I as a physician with my salary find prohibitive. Imagine the plight of the person who works at the front desk in my office, has the same healthcare insurance that I have, but cannot afford the copays or the deductibles for the sleep study and the CPAP machines, and therefore cannot “access” the best healthcare in the world.

In the Delaware valley area, where I practice at a university hospital, there are at least 35 AASM accredited sleep labs serving a population of roughly 6 million people. With an average of 6 beds per lab, one bed serves 25,000 people. In my opinion that is one bed too many. Not one of these accredited sleep labs is offering ambulatory monitoring and treatment with auto CPAP in any meaningful way. Institutions like mine and the other university hospitals are not embracing this technology because of discomfort with anything new, and dare I say it, because of the loss of revenue that this would bring to the institutions. However, this is being practiced at the VA Medical center in Philadelphia. If this modality of testing and treatment is appropriate for our veterans, why not for others? We will get the best “bang” for our buck and make sleep testing and treatment for sleep apnea more “accessible.” Along the way, we will gather data and push the envelope, in making this technology available beyond what is currently recommended.

The AASM and all the people in leadership positions need to focus on getting testing and treatment outside the sleep lab. At a minimum we should adopt the recommendations as published in 2007.³ The AASM recently published an article recommending use of PSG for chronic hypoventilation syndromes.⁴ These guidelines were based for the most part on Level 4 evidence. In my opinion, none of the references cited in the article had any relevance to the recommendations made.

We should not be waiting for the way we deliver healthcare to be forced upon us by the insurance companies. The big concern is loss of revenue from the sleep studies for the institutions and free-standing sleep labs. The AASM needs to take a leadership position on developing economic models that can preserve and maintain the salaries that in my opinion physicians deserve. But we should make our living from diagnosing and treating patients and not from ordering expensive tests.

As a junior faculty member in an academic institution in a major metropolitan area, I am not only frustrated and disillusioned by our current health care “practice,” but also by the lack of leadership shown by the AASM. It is time for the leaders of our academic institutions, especially the ones who have a leadership position in the AASM, to lead on this issue.

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Address correspondence to: Ritu G. Grewal, M.D., Assistant Professor of Medicine, Pulmonary Division, Sleep Disorders Center, Thomas Jefferson University Hospital, 211 South, 9th Street, Philadelphia, PA 19107; Tel: (215) 459-3230; Fax: (215) 955-9783; E-mail: ritu.grewal@jeffersonhospital.org

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