Since 2008, the FDA has approved a higher percentage of drugs than previously, and cancer drugs are approved on the basis of surrogates that have poor correlations with overall survival. Our results suggest that the FDA may be approving many costly, toxic drugs that do not improve overall survival. Enforcement of postmarketing studies is therefore of critical importance.

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LESS IS MORE

Appropriate Prescribing for Patients With Diabetes at High Risk for Hypoglycemia: National Survey of Veterans Affairs Health Care Professionals

Evidence is accumulating that older individuals with diabetes mellitus have little to gain from the treatment burdens of stringent blood glucose control. In addition to concerns about increased mortality with tight control, some older patients with diabetes may also be at risk for hypoglycemia-related harms from medications prescribed to meet standard hemoglobin A1c (HbA1c) targets. This problem has motivated patient safety campaigns that cue health care professionals to limit medications for certain older patients (eg, those with an HbA1c level <7.5%, renal disease, or dementia) to convert HbA1c to a proportion of total hemoglobin, multiply by 0.01. In this study, we examined beliefs of primary care health-care professionals (PCPs) to anticipate how PCPs might receive such recommendations.

Methods We surveyed a national random sample of practicing nontrainee Department of Veterans Affairs (VA) PCPs, including physicians, nurse practitioners, and physician assistants. The study, including a waiver of signed informed consent, was approved by the institutional review board of the Ann Arbor VA Healthcare System and was conducted from October 6, 2014, to December 8, 2014. Participants answered questions about practice characteristics, performance incentives, beliefs about decreasing use of inappropriate services, and demographics. They also received a scenario about a 77-year-old man with long-standing type 2 diabetes mellitus at high risk for hypoglycemia (HbA1c level, 6.5%; severe kidney disease; and receiving glipizide, 10 mg, twice daily). Barriers to and facilitators of medication deintensification were identified using statements answered on a 4-point scale (strongly disagree to strongly agree) (Table 1). In addition, participants were asked to rate the level of difficulty they anticipated in following the Choosing Wisely recommendation to “avoid using medications other than metformin to achieve HbA1c less than 7.5% in most older adults.” Data were analyzed from March 18, 2014, to April 2, 2014. We used logistic regression to identify PCP and practice setting characteristics associated with anticipated difficulty following the Choosing Wisely HbA1c recommendation.

Results Of 1222 eligible PCPs, 594 returned usable surveys (48.6% response rate; numbers vary due to item nonresponse). Of these, 311 (53.0%) were women, 138 (23.4%) were nurse practitioners, 46 (7.8%) were physician assistants, and 405 (68.8%) were physicians.

A total of 217 PCPs (38.6%) thought that the 77-year-old patient at high risk for hypoglycemia would benefit if his HbA1c level was maintained below 7.0%, and 252 participants (44.9%) reported that they would not worry about potential harm from tight control. In addition, 236 PCPs (42.1%) would worry that deintensification in this context (HbA1c level, 6.5%) would lead to an HbA1c level that is outside of current performance measures; 132 of the participants (23.5%) worried that deintensification could leave them vulnerable to future malpractice claims. Table 1 presents participant responses to all scenario questions.

A total of 161 of 562 PCPs (28.7%) agreed it would be somewhat or very difficult to follow the Choosing Wisely HbA1c recommendation for older adults. The PCPs who agreed that maintaining the HbA1c level below 7.0% would benefit the patient and who reported worrying about malpractice claims were more likely to report difficulty following the HbA1c recommendation in the final adjusted regression model (P = .02). Conversely, PCPs who reported worrying that the patient would be harmed with tight blood glucose control were less likely to report difficulty following the HbA1c recommendation (P = .04) (Table 2).
**Discussion** | Almost half of VA PCPs reported that they would not worry about harms of tight control for an older patient with an HbA1c level of 6.5% who is at high risk for hypoglycemia. A similar proportion were concerned about not meeting performance measures if they reduced the glipizide dosage, even though the VA never adopted a performance measure target-
tion and deintensification could improve prescribing practices and prevent many adverse events in older patients with diabetes.

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COMMENT & RESPONSE

Communicating With Patients—The Other Side of the Conversation

To the Editor In an article recently published in JAMA Internal Medicine, Nakagawa1 describes 2 key revelations concerning communicating with patients and/or their families. First, communicating bad news is akin to performing a surgical procedure, and second, that as he was developing his communication skills, he lacked real-time feedback. As a physician communication coach, I agree with Dr Nakagawa’s steps—prepare, proceed, review. However, Nakagawa’s procedure focuses only on well-chosen words in ideal patterns, which is just one side of the issue.

Communication happens with patients and their families. It begins as an abiding concern for people that we, as medical professionals, get to practice long before the need for a crucial conversation. During our training, we see and relate with appropriate concern in appropriate measure to nurses, colleagues, students, technicians, housekeepers, and people we pass in the hall. The other side of Nakagawa’s procedure is “reflection-in-action,”2 ie, attentiveness during the conversation.

Patients and their families, as well as colleagues and others, give instant feedback as we speak with them. The real-time feedback Nakagawa felt deprived of always was there. The tic of an eyelid, the words that catch or do not flow fluently, and the questions we are asked, tell us how patients and their families, as well as others, are responding to the situation and to our words.

From the beginning of medical school we should learn the specific nonverbal and verbal elements of creating relationships in the same way that a surgeon must anticipate and react to the anatomy she or he encounters. These skills are more, not less, important for surgeons. Surgeons have fewer meetings and less time to establish meaningful, helpful relationships with patients. Their interactions almost always happen over or during complex, dramatic circumstances when misunderstandings are easy to come by. Surgeons and emergency physicians must rapidly capture and prove they deserve a patient’s trust.

Charlton and Stern3 indicate that relationships are antidotes to burnout and key to developing empathy. Detachment (ie, depersonalization) converts a demanding profession into ungratifying work. As Beach et al4 indicate, all