groups are generally funded by hospitals, we were surprised that perceptions of hospital support were not associated with risks for burnout and low satisfaction. This suggests that even though relationships with their hospital are critical for financial and strategic success, direct support from divisions appears to be more critical for hospitalists’ career satisfaction and burnout. Nearly 90% of respondents reported to a general internal medicine chief, which suggests a need for general internal medicine division chief support to balance work demands, schedules, and protected time in a manner consistent with academic success.

Our study had several important limitations. First, we studied only a subset of hospitalists from primarily larger academic institutions known to the study authors. It is likely that scholarly infrastructure, support, and expectations are different in these institutions than other types of teaching hospitals, reducing the generalizability of our data. Next, our study design was prone to response bias and we did not assess the actual vs reported academic productivity of respondents. Finally, low satisfaction, stress, and burnout were assessed through subjective assessment tools.

In conclusion, few academic hospitalists have succeeded in achieving senior levels of promotion. This is likely owing, in part, to the youth of the field and inadequate amounts of protected scholarly time fueled by high demands for nonteaching clinical work. However, the resultant high levels of stress and burnout and low satisfaction may also present a real threat to the vitality of a budding field. Targeted efforts and interventions are needed to stem this tide in order to create fulfilling, sustainable, and scholarly, robust academic hospitalist careers.

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With 90% of Medicare FCA settlements in this period, two-thirds of the more recent Medicaid settlements did not involve qui tam relators. These investigations were frequently initiated by state attorneys general or Medicaid officials and conducted jointly with federal investigators and other state attorneys general. The investigations have primarily involved pharmaceutical manufacturers, who account for $4.7 billion in financial recoveries and 43% of successfully concluded Medicaid FCA investigations.

Our analysis has some limitations. Our data consist of publicly disseminated information. However, there are no public databases containing information on health care fraud. With continuing Medicaid growth, the number of fraud investigations initiated by state officials will increase. The consequences of these efforts have the potential to reduce costs and improve the quality of care received by Medicaid enrollees.

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Comment. We identified 56 successfully concluded Medicaid FCA investigations associated with $5.5 billion in financial recoveries, with almost all of the recoveries occurring since 2006. The most pervasive allegations involved billing fraud and off-label marketing by pharmaceutical manufacturers. While all of the initial Medicaid FCA settlements involved qui tam relators, as was the case with 90% of Medicare FCA settlements in this period, two-thirds of the more recent Medicaid settlements did not involve qui tam relators. These investigations were frequently initiated by state attorneys general or Medicaid officials and conducted jointly with federal investigators and other state attorneys general. The investigations have primarily involved pharmaceutical manufacturers, who account for $4.7 billion in financial recoveries and 43% of successfully concluded Medicaid FCA investigations.

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Table. State-Initiated False Claims Act Case Settlements Involving Medicaid Fraud by Industry and Type of Fraud, 1996-2009

<table>
<thead>
<tr>
<th>Industries</th>
<th>No. of Cases</th>
<th>Total Recoveries, $, in Millions</th>
<th>Billing Fraud, $, in Millions (No. of Cases)</th>
<th>Kickbacks, $, in Millions (No. of Cases)</th>
<th>Off-Label Marketing, $, in Millions (No. of Cases)</th>
<th>Withholding Information, $, in Millions (No. of Cases)</th>
<th>Hiring Unqualified Nurses, $, in Millions (No. of Cases)</th>
<th>Switching Prescriptions, $, in Millions (No. of Cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>24</td>
<td>4688</td>
<td>1614 (19)</td>
<td>NA</td>
<td>2424 (3)</td>
<td>650 (2)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Hospital networks, hospitals, university medical centers</td>
<td>9</td>
<td>490</td>
<td>230 (7)</td>
<td>35 (1)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>6</td>
<td>221</td>
<td>10 (2)</td>
<td>112 (1)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>99 (3)</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>5</td>
<td>28</td>
<td>4 (2)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>24 (3)</td>
<td>NA</td>
</tr>
<tr>
<td>Medical devices</td>
<td>3</td>
<td>43</td>
<td>2 (1)</td>
<td>40 (1)</td>
<td>1 (1)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Home health care</td>
<td>1</td>
<td>2</td>
<td>2 (1)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>1</td>
<td>1</td>
<td>1 (1)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Laboratory</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>End-stage renal disease providers</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Health insurance</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Medical professionals and small practices</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>56</td>
<td>6 (3)</td>
<td>50 (4)</td>
<td>NA</td>
<td>NA</td>
<td>24 (3)</td>
<td>225 (1)</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>5529</td>
<td>1869 (34)</td>
<td>237 (7)</td>
<td>2425 (5)</td>
<td>650 (2)</td>
<td>24 (3)</td>
<td>99 (3)</td>
</tr>
<tr>
<td>% Of total settlements (%)</td>
<td></td>
<td></td>
<td>34 (64)</td>
<td>4 (13)</td>
<td>44 (7)</td>
<td>12 (4)</td>
<td>0.4 (5)</td>
<td>4 (2)</td>
</tr>
</tbody>
</table>

Abbreviation: NA, not applicable.
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of the manuscript for important intellectual content: Qures-
shi, Liu, Sartor, Chu, and Bennett. Statistical analysis: 
Qureshi, Chu, and Bennett. Obtained funding: Bennett. 
Administrative, technical, and material support: Bennett. 
Study supervision: Qureshi, Sartor, and Bennett.

Financial Disclosure: None reported.

COMMENTS AND OPINIONS

Dual Antiplatelet Therapy and 
the Risk of Bleeding

W

e applaud Hansen and colleagues1 for calling 
attention to the risk of bleeding with single, dual,
or triple therapy with warfarin, aspirin, and clopidogrel in 
patients with atrial fibrillation. Although the authors 
highlight the increased risk of bleeding with all 
combinations of these medications, we believe that one 
observation in this article is worthy of special 
emphasis, because it is not only important but also may be 
unknown to many clinicians. Figure 3 of their article1(p1438) 
shows that the risk of bleeding for patients receiving 
combined treatment with aspirin and clopidogrel, which 
are known to increase the risk of bleeding, is significantly 
higher than the risk for patients treated with warfarin alone. 
This finding should be important to clinicians who make 
treatment recommendations to patients with atrial fibrillation 
and vascular disease. It is consistent with the earlier Atrial 
Fibrillation Clopidogrel Trial With Irbesartan for Prevention of 
Vascular Events (ACTIVE W) trial,2 in which the risk of minor 
bleeding and total bleeding was significantly higher for patients 
with DAPT than with single antiplatelet therapy. DAPT should 
be better recognized and appreciated.

If any, circumstances in which DAPT would be justified 
for stroke prophylaxis in this condition. Second, these 
findings should help clinicians counsel patients for whom a 
drug-eluting stent (DES) is a treatment option. In light of 
these findings, clinicians considering whether to recommend 
this treatment strategy should carefully assess a patient’s risk 
of bleeding and falls, as much as they would when considering 
warfarin anticoagulation. It should be remembered that DAPT is recommended for an even longer treatment 
duration after DES placement3 than oral anticoagulants (OACs) are for deep venous thrombosis or pulmonary embolism.4

Third, the relative bleeding risk of DAPT compared with OACs should be of great interest to those who work to ensure patient safety. The Joint Commission Hospital National Patient Safety Goals include a measure to reduce harm from anticoagulation therapy (NPSG.03.05.01).5 This measure targets patients receiving any form of heparin or warfarin, but there is no similar safety goal for patients receiving DAPT. We believe that the risk of bleeding for patients receiving DAPT should be better recognized and appreciated.

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Financial Disclosure: None reported.

In reply

We appreciate the interest of our esteemed colleagues, Ziegel-
stein et al, in our work.1 They raise an important issue of the 
bleeding risk with dual aspirin and clopidogrel therapy in 
patients with atrial fibrillation. We share their thoughts and agree that this issue merits special emphasis. Therefore, we would like to highlight 2 clinical important messages. First, dual aspirin and clopidogrel should not be a treat-
ment regime on patients who do not receive OAC therapy.

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Corrections: Corrected on April 25, 2011

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787

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