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Empiricism as Change Agent

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Empiricism as Change Agent

American public attitudes towards controversial social issues like race, immigration, criminal justice, reproduction and sex have never been static. Yet it would be hard to imagine a more abrupt change in public opinion than has been seen with gay marriage just since 2001. In a report issued last year by the Pew Research Center, the proportion of all Americans supporting legal marriage for gays and lesbians increased from 35% to 55%. Even more astounding, support increased across all subgroups, including Baby Boomers (from 32% to 45%), Catholics (from 40% to 57%), and registered Republicans (from 21% to 32%).

Acceptance of transgender Americans has come more slowly. According to a 2013 Pew survey involving more than one thousand LGBT respondents, 80% felt that there was “little” or “no” public acceptance of transgender people. But this too is changing. We find it easier to accept that with which we are familiar. Popular interest in Caitlyn Jenner’s story and in Jill Soloway’s television hit, “Transparent,” may signal a similar “trans-formation” of public attitudes. And as transgender people emerge from obscurity, both in real life and in the media, society will inevitably transition towards greater acceptance.

In historical terms, medicine can hardly claim to have outpaced society as a whole on social issues. If we have made progress, it is partly by allowing empiricism to challenge ideology. In this issue of *JGIM*, Padula, Heru and Campbell (1) provide robust empirical support for coverage of transgender health care needs, including gender transition services. In their cost-effectiveness analysis, the authors found that insurance coverage for transgender services could be provided at an incremental cost-effectiveness ratio (ICER) of \$9314 and would result in a premium increase of about 1.5 cents per member per month. These highly favorable projections were driven by reductions in depression, suicide, drug abuse, and HIV infection among recipients of transgender transition services. This information should be useful to policymakers making coverage determinations.

Providing high quality care to every patient, every time is the goal of every internist. Just as achieving access to necessary services is one dimension of quality, avoiding unnecessary or inappropriate care is another. Proton pump inhibitors (PPIs) are among the most frequently prescribed medications in the United States. Among outpatients, these agents are most often prescribed for treatment of esophageal reflux and dyspepsia. Among inpatients, the list of indications expands to include both treatment and prophylaxis. Yet within hospital settings, these agents raise the risk of both healthcare facility-associated pneumonia and clostridium difficile infection. In this issue, Pappas et al. (2) run a micro-simulation showing that for most inpatients not in the intensive care unit, the risks of PPIs far outweigh the benefits. An accompanying editorial by Herzig and Nardino (3) puts the findings in context.

Beyond access and appropriateness, another critical dimension of quality is execution. To paraphrase Goethe, knowing is not enough, we must do. And in doing, we need to get the right treatment to the right patient, at the right time, in the right way. The article by Tosteson et al.(4) highlights some of the barriers to accomplishing this. In this paper, the authors show that a substantial proportion of abnormal cancer screening tests are not adequately followed up. But beyond the usual lament, their analysis provides new insights by adopting a comparative approach: they show that follow-up is much better for

mammography than for abnormal Pap smears or for positive stool occult blood tests. They conclude that “variation in timely screening abnormality follow-up...may be influenced by patient and system characteristics as well as differences in the underlying complexity of coordinating the next steps in clinical care.” Understanding the context of failure may be equally or more important than documenting the deficiencies themselves.

A systematic review in this issue also addresses the broad issue of execution. The paper by Luu et al. systematically examines the literature on provider-to-provider communication during transitions from outpatient to acute care. The major finding is that the research landscape is relatively barren, with only three randomized controlled trials evaluating the relationship between communication quality and 30-day readmission rates. While *JGIM* is hardly averse to publishing groundbreaking findings (authors: please note), we believe it is important to document the state of the evidence with respect to important clinical and educational questions, even when the evidence is scant.

That's the problem with empiricism: sometimes the facts themselves are distressingly elusive. But in the long run, we're probably better off with elusive facts than self-evident ideologies.

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