Books, the Children of the Brain

'The Promise of Sleep'

We've all heard that the Exxon Valdez was run aground in 1989 by a skipper who had been drinking. Given the magnitude of the oil spill in Alaska's Prince William Sound, the story of the unfortunate skipper has lived with us for many years.

BY RODRIGO A. MUÑOZ, M.D.

In "The Promise of Sleep" (New York: Delacorte Press, 1999), William C. Dement, M.D., and coauthor Christopher Vaughan tell us the real story: The third mate—not the skipper—was in charge, and the third mate, having had only 6 hours of sleep in the previous 48, ordered the helm to starboard without noticing that the autopilot was still on. Addled by what Dr. Dement refers to as "sleep debt," the third mate twice failed to heed warnings before he noticed, too late, that the autopilot had prevented his course correction from taking effect.

Dr. Dement, who almost single-handedly established the study of sleep as an area of scientific research and the treatment of sleep disorders as a medical specialty, wrote this book for the general public, but it has a great deal to say to physicians, especially those in primary care and psychiatry.

How common is sleep deprivation? Dr. Dement believes that fully half of us mismanage our sleep enough to negatively affect our health and safety. "I have observed people staggering through their lives in a daze," he writes, "misunderstanding the roots of their sleepiness, or not even recognizing that they are sleepy."

The electric light, the demands of modern life, and the seductions of late-night television, e-mail, and other distractions have increased our national sleep debt to the point where driving while drowsy causes at least as many accidents as driving while intoxicated. In a survey by the National Sleep Foundation, 23% of a random sample admitted falling asleep while driving in the past year.

In his 50-year career, Dr. Dement has made too many contributions to sleep medicine to tally here. He identified and named rapid eye movement (REM) sleep as well as the four stages of non-REM sleep. He determined that most dreaming occurs during REM. He pioneered all-night polysomnography for the diagnosis of sleep disorders, and he has been a tireless promoter of proper sleep hygiene. An excellent medical politician, he has made enormous efforts to recruit and educate new researchers, new clinicians, and new advocates in the difficult field of sleep disorders.

The key to better sleep in today's world, he says, is to reduce our sleep debt to manageable levels. When we don't sleep long enough, the brain keeps an exact accounting of how much sleep is owed. And that sleep debt may be collected any time. He tells one story of a physician who actually fell asleep while using a stethoscope to listen to a female patient's heart. She was startled and very upset when his head fell onto her naked breast.

It turned out that the physician had obstructive sleep apnea and was waking 50 times an hour throughout the night. At the time (about 25 years ago), the only treatment for this very common disorder was tracheostomy because continuous positive airway pressure (CPAP) had not yet been developed. The physician underwent the surgical procedure and has led a productive professional life ever since.

Sleep debt, whether caused by apnea, insomnia, or a stressful life, often masquerades as a psychiatric disorder. Adults are misdiagnosed with treatment-resistant depression, and children receive mistaken diagnoses of attention deficit disorder.

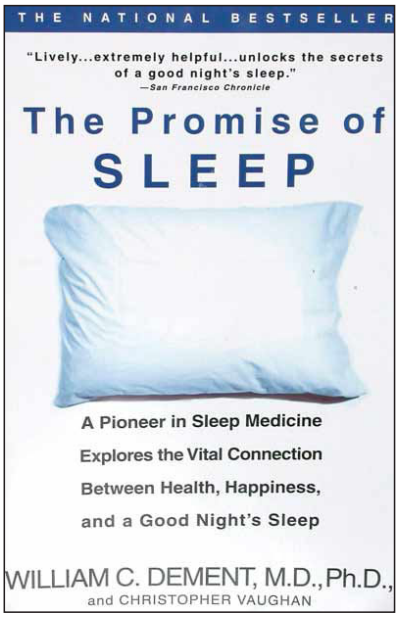
Dr. Dement tells the story of a high-achieving Silicon Valley executive who had been fired because of poor performance and whose irritability had cost him his marriage. Diagnosed with bipolar disorder, he'd been taking lithium for 5 years. Despite taking sleep medication at bedtime, he came to the clinic complaining of severe insomnia and daytime blackouts. Dr. Dement found him pacing around the waiting room and, once inside the exam room, the patient complained, "I just can't sit still."

The diagnosis was restless legs syndrome. People with this syndrome suffer uncomfortable and sometimes painful feelings in the limbs that create an irresistible desire to move them, causing difficulty sleeping. The person may flex, stretch, and cross the legs to ease the discomfort. The feelings may be relieved, but may return minutes later. As many as 1 person in 10 may suffer from this disorder.

Psychiatrists know that hypersomnia and insomnia can both be manifestations of psychiatric disorders. Most cases of insomnia we see are also cases of depression. Considering that depression is one of the most common disorders in medicine and that it is serious, disabling, and too often lethal, I would have hoped for a longer exposition of Dr. Dement's ideas about the diagnosis and treatment of depression, especially because psychiatrist David J. Kupfer, M.D., had success in using latency of REM sleep as an indicator of the outcome of therapy.

This may be too much to ask when one considers that the book is already an excellent aid for both patients and physicians, containing detailed recommendations for determining one's own sleep debt and devising a strategy to repay it.

According to Dr. Dement, 40% of the population suffers from some level of sleep apnea, and at least half of those have clinically significant symptoms. Yet, how many physicians consider that out of every five patients walking through the door, one is likely to have this disorder? ■



The brain keeps track of our sleep debt, Dr. Dement says, and it may collect at any time.

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Financial Benefits of Medicaid Managed Care Appear Elusive

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

Washington — Medicaid managed care doesn't appear to be living up to its reputation for cost savings, at least not in South Carolina, Walter Jones, Ph.D., said at the annual meeting of the American Public Health Association.

Dr. Jones and his colleagues looked at 2 years' worth of data on 56,000 Medicaid HMO patients and 21,000 patients in the state's Physician Enhanced Payment (PEP) program, a Medicaid plan in which primary care physicians are paid an extra fee to "case manage" the patient's health care needs. Both groups were matched with comparable fee-for-service patients.

South Carolina "is not a heavily managed care state. We have very little HMO penetration," said Dr. Jones, professor of health administration and policy at the Medical University of South Carolina, Charleston. "Unlike a lot of Medicaid programs, South Carolina does not have mandatory HMO assignment; physicians wouldn't stand for it. As a consequence … there's been a lot of unstable provider participation. An HMO comes to the state, thinks it can make money, finds it can't, and leaves, and the merry-go-round goes on and on."

But the PEP program is a much different form of managed care, he said. The primary care physician provides a "medical home" for the patient for a flat fee but is not financially penalized for putting a patient into specialty care. Also, PEP physicians are expected to be "very available," reducing the need for costly emergency room care, Dr. Jones said.

The researchers looked at several aspects of medical care utilization, including primary and specialty care, inpatient hospitalizations, and emergency room visits. They also included a separate category for "total utilization," which included pharmacy use and other services as well as physician and hospital care.

They found that on the surface, both HMOs and PEP reduced utilization. Patients in HMOs had five fewer health care visits for a 2-year period, compared with fee-for-service patients, and PEP patients had two fewer visits. But there was a problem among the HMO patients: the reduced visits included those for primary care as well as for specialty care.

"That's not what managed care is supposed to be doing," Dr. Jones said. "With the PEP project, utilization goes down a little less, but there's no difference in primary care utilization. It appears … that PEP is doing exactly what it should be doing—controlling utilization but not on the primary care level."

Another problem with the HMOs, he continued, is that they "cream skim." "When you control for the HMOs' patient selection, their utilization differences disappear with respect to fee for service. The way they're reducing costs is by keeping the less desirable clients out." This is often accomplished by not setting up enrollment offices in areas of the state where sicker patients are more likely to live, he told this newspaper.

Although patients in both PEP and the Medicaid HMOs decreased their utilization of certain kinds of care, total health care utilization actually appeared to go up in both groups, Dr. Jones noted.

"If you're the state and you're trying to save money, you might be kind of dismayed. On the other hand, if you're an advocate for patients, it doesn't appear that applying managed care reduces the number of services," he said.

Overall, the study "raises questions about the utility of Medicaid managed care," he said. "The assumption always has been that HMOs or other managed care plans could do for Medicaid clients what it's done for private sector healthy employees; we haven't found that to be true. The bottom line is, it's still kind of 'faith-based' health care." ■