

cians prescribed buprenorphine or methadone in 4.8 million visits and acamprosate, disulfiram, or naltrexone in 1.5 million visits. Physicians provided psychosocial therapy in an estimated 24.9 million visits, representing 59% of all visits. This proportion did not change significantly over time ($P = .87$). In multivariable models, time period was independently associated with pharmacotherapy (odds ratio [OR], 3.3 for 2007-2009 vs 2001-2003; 95% CI, 1.7-6.1) but not psychosocial therapy (OR, 0.8 for 2007-2009 vs 2001-2003; 95% CI, 0.5-1.3). However, neither therapy was provided in 15.4 million visits, accounting for 36% of visits and not varying significantly over time ($P = .76$).

Comment. In this nationally representative sample of adult ambulatory visits, visits involving a substance use disorder increased substantially between 2001 and 2009. Opioid use disorders accounted for a markedly increased share of visits over time. This finding is consistent with trends in substance use disorder-related utilization at the nation's community health centers and emergency departments and, sadly, use of its morgues.^{2,7,8} Our study provides reason for optimism, however. Visits involving provision of pharmacotherapy increased as well, likely driven by the use of buprenorphine. Increasing recognition of previously undiagnosed disorders, improving familiarity with and use of available medications, and more frequent ambulatory care by individuals with substance use disorders all likely contribute to the trend of increasing visits over time. As millions of visits did not involve treatment, there remains both an opportunity and a need for further expansion of treatment within ambulatory settings.

Our study has several limitations. First, the cross-sectional, visit-based nature of the data precludes causal inferences. Residual confounding is possible, and underdiagnosis is likely. Finally, the NAMCS/NHAMCS lacks detailed clinical information, so we could not assess the appropriateness of management decisions by health care providers.

The Mental Health Parity and Addiction Equity Act of 2008 (Pub L No. 110-343) and the Patient Protection and Affordable Care Act of 2010 (Pub L No. 111-148) will provide increased support for the management of substance use disorders in ambulatory settings.⁴ Our study provides an important assessment of the national impact of substance use disorders in ambulatory care at a time when these laws have the potential to transform the US health care system's ability to care for the millions of Americans struggling with these disorders.

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Mexico-United States Migration and the Prevalence of Obesity: A Transnational Perspective

Country of birth and length of stay in the United States have proven to be strong predictors of obesity among Mexican Americans,¹ suggesting the US environment may be distinctively "obesogenic."² For example, a 12-oz bottle of American-made Coca-Cola has

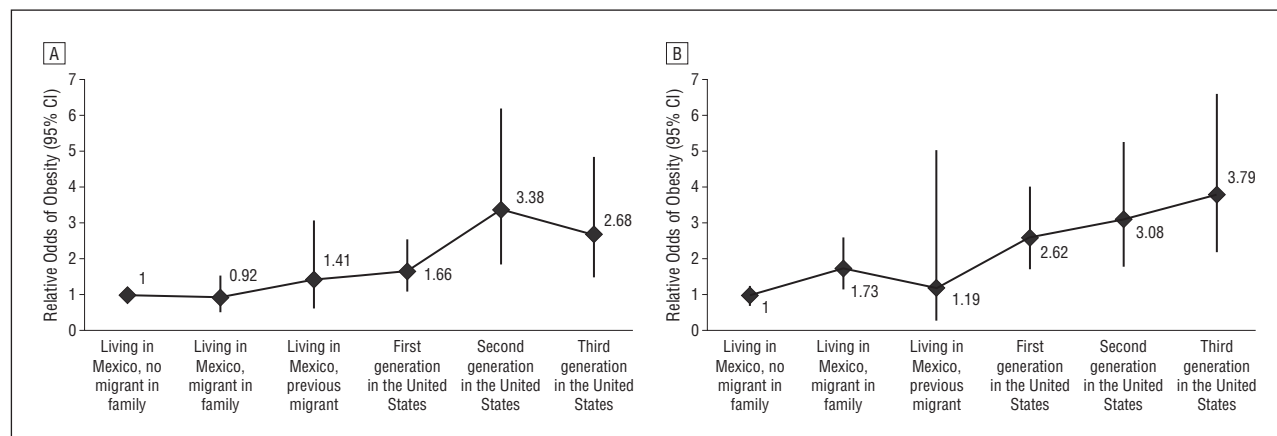


Figure. Relative odds of obesity associated with migration in Mexico and the United States. A, Men. B, Women.

240 calories with 65 g of sugar, whereas Mexican-made Coca-Cola has 150 calories per 12-oz bottle with 39 g of sugar (the former is made from high-fructose corn syrup).^{3,4} However, there is also evidence that immigrants are resistant to these influences: growth in body mass index (BMI), calculated as weight in kilograms divided by height in meters squared, is slower among immigrants than among US-born Mexican Americans.⁵ Studies have yet to examine the relationship between migration and obesity in a transnational perspective, including comparisons with the Mexican source population to help identify patterns distinctive to the United States.

Methods. Data from epidemiological surveys in Mexico (the Mexican National Comorbidity Survey⁶ [MNCS]) and the United States (the Collaborative Psychiatric Epidemiology Surveys⁷ [CPES]) were combined (N=3244 respondents). Obesity was defined as a BMI greater than 30 using self-reported height and weight. Respondents with missing weight or height (n=266 respondents), implausibly high BMI (>65) (n=3 respondents), and current pregnancy (n=62 respondents) were excluded. Comparison groups were defined using information on respondents' personal and familial connection to Mexico-US migration. The MNCS respondents were divided into 3 groups: (1) Mexicans who have never been to the United States and do not have a migrant in their immediate family (living in Mexico, no migrant in family; n=1050); (2) Mexicans who have not been to the United States but have a migrant in their immediate family (living in Mexico, migrant in family; n=955); and (3) Mexicans who have previously been migrants in the United States (living in Mexico, previous migrant; n=126). Respondents in the United States were also divided into 3 groups: (1) Mexican-born immigrants (first generation in the United States; n=509); (2) US-born with 1 or more Mexican-born parent (second generation in the United States; n=285); and (3) US-born with US-born parents who self-identified themselves as Mexican American (third generation in the United States; n=319). Covariates included age (continuous), marital status (married, divorced, never married), educational attainment (0-5, 6-8, 9-11, or ≥12 years), and current smoking status. Analyses were conducted

using SUDAAN software (SAS Institute Inc) to adjust for the complex survey design.

Results. With statistical adjustment for age, marital status, education, and smoking, the odds of obesity among men were higher among the first generation in the United States (odds ratio [OR], 1.66 [95% CI, 1.10-2.52]), the second generation in the United States (OR, 3.38 [95% CI, 1.84-6.20]), and the third generation in the United States (OR, 2.68 [95% CI, 1.48-4.86]), relative to men living in Mexico, with no migrant in family (**Figure**). Among women, the adjusted odds of obesity were higher for the first generation in the United States (OR, 2.62 [95% CI, 1.72-4.00]), second generation in the United States (OR, 3.08 [95% CI, 1.81-5.23]), and third generation in the United States (OR, 3.79 [95% CI, 2.19-6.57]) relative to women living in Mexico with no migrant in family. Among women but not among men, respondents living in Mexico with a family member in the United States were more likely to be obese than those with no migrants in their family (OR, 1.73 [95% CI, 1.14-2.62]). Also see the eTable (<http://www.archinternmed.com>).

Comment. Consistent evidence reveals greater odds of obesity among US-born Mexican Americans relative to their first-generation counterparts. This study extended this comparison by including those in Mexico and revealed that the gap between first-generation immigrants and the US-born is one part of a graded increase in obesity associated with migration to the United States. This is important in light of a longitudinal analysis that suggested that first-generation immigrants may be resistant to the obesogenic environment in the United States.⁵ This cross-sectional comparison suggests otherwise. We found slight differences by sex, but results indicate a roughly 3-fold increase in obesity from one extreme to the other for both sexes.

Second, we found that among Mexicans with no direct migration experience, having a migrant in the immediate family is associated with a higher risk for obesity among women but not for men. This finding may reflect economic influences on diet, such as cash remittances sent by migrants working in the United States.

Findings should be interpreted in light of the use of cross-sectional data and reliance on self-report of height

and weight. Self-reports tend to underestimate the prevalence of obesity, but evidence suggests that self-report does not differ between immigrant and US-born Mexican Americans, except for those who are underweight.⁸

Migration is a transnational process that is likely to have a range of health effects in both sending and receiving countries, including diet. Given that obesity is a risk factor for the major causes of mortality in this country, growing rates among Mexican Americans is of public health and clinical urgency.

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The Earlier the Longer: Disproportionate Time Allocated to Patients Discussed Early in Attending Physician Handoff Sessions

Handoffs in hospitals have been widely recognized by both regulators and researchers as a locus of potential communication failure, with substantial risks to patient safety and quality of care.^{1,2} By conservative estimate, there are over half a billion patient handoff discussions annually in US hospitals. Most empirical studies have been performed in shift-change settings, where most handoffs occur, and where it is typical that responsibility for multiple patients is transferred during a single handoff session. However, theoretical analysis in the literature is entirely focused on how best to hand off a single patient.³⁻⁵ As a result, research has overlooked what has been labeled *the portfolio problem*: how best to allocate across multiple patients the scarce time available for a handoff session.⁶

In the first study of this issue, to our knowledge, we used video recordings of 262 patient discussions in 23 handoff sessions among experienced attending physicians in the intensive care unit (ICU) of a tertiary medical center. We found that first-discussed patients received about 50% more time than those discussed last in a session. This occurred despite the order of cases being effectively random and therefore unrelated to severity or complexity of illness.

Methods. We recorded 23 end-of-week handoff sessions that occurred just prior to the transfer of responsibility for the 21-bed ICU. The unit was staffed by 2 teams, each led by an outgoing attending physician who handed off to an incoming one. Our study was approved by the Queen's University ethics board (Kingston, Ontario, Canada) and included 10 highly experienced physicians with a median of 9 years as an attending physician.

The procedure followed in this ICU was to discuss patients in bed-list order, not according to severity. We confirmed this in interviews and determined that ICU bed assignment itself did not relate to acuity or complexity. With unpredictable patient arrivals and all rooms equally equipped, the discussion order of the cases was effectively randomized, making severity of illness or other patient characteristics unrelated to discussion order.

Our main measures of interest were constructed from the videos: the number of patient discussions in each session, the ordinal position of each discussion in its session, and its duration. To determine whether our hypothesized negative relationship of order and length of discussion was statistically significant, we computed the Kendall τ rank order coefficient within each session. To