PSA

# Patient Safety America Newsletter

February 2011 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: Irresponsible prescribing of antibiotics has allowed the emergence of lethal super-bugs. How many years ago were critical studies published in the New England Journal of Medicine outlining how to control this threat? a) 100 b) 75 c) 50 d) 25 e) 10*

Book Review:

**Partners in Health: How Physicians and Hospitals Can Be Accountable Together**

Editors: Francis Crosson and Laura Tollen
Publisher: Jossey-Bass, 2010

This book is a collection of essays by experts in the field of healthcare delivery, edited by two experts from the Kaiser Permanente Institute for Health Policy. I knew I was going to like it when I read the dedication: "To all those in America who lack access to affordable, high-quality healthcare." That's most of us. When did you last have access to affordable ***and*** high-quality healthcare in America? I was reminded that my wife must find another internist because she does not want to pay $1800 per year *up front* for access to the doctor she has had for years. No money, no access.

The forward to the book points out that the cost trajectory we are on is unsustainable and that fragmentation and failure to practice evidence-based medicine cannot continue. In other words 'care' that ensures no benefit to the patient and may often harm patients must disappear.

The central purpose of this book is to trace the relationships that have unfolded between doctors and hospitals since the late 1800s. The authors offer various partnership solutions that would work to improve access, quality, and costs. I might roughly observe that the description of the hospital-physician relationship they describe is like a love-hate relationship. Physicians and hospitals need each other to exist; however, who dominates, calls the shots, and makes the money have all been points of contention. Over the years the government has tried to manage this relationship with mixed success. Overall, I believe the authors view government intervention as a negative force in improving the hospital-physician relationship. It has rarely been about patient-centered healthcare.

Now physicians and hospitals are being forced by circumstances into closer relationships, with hospitals now dominating the partnership. Gradually more physicians are becoming hospital employees instead of independent occupants of hospital service wings. This means that they are subject to closer management by hospitals and their autonomy fades. Hospitals are becoming more involved in outpatient services where the tensions between hospitals and physicians are an ongoing battle, fought on a more level playing field than *in* hospitals. The winners in this battle are the ones who take away the most money and not the ones who provide the best patient-centered care. The writers offer ways to change that emphasis and describe past efforts that have failed.

Attempts are being made to foster pay for performance, but how does one really measure


performance. Experts can argue about this in considerable depth. It seems that now the pay

offered for improved performance may be insufficient to warrant widespread improvements. I note on page 83 that the writer talks about the 'carrot' of improved payment and the 'stick' of no payment when the hospital is forced to treat complications of 'never events' that their staff caused. These events include operating on the wrong body part or patient. I might note that until recently physicians were actually paid their fee by Medicare for operations performed on the wrong patient or body part. The stick is small, but growing.

This book was written for professionals directly engaged in the improvement of healthcare. It should be read by those individuals and by healthcare 'experts' that serve legislators in their states and in our nation's capital. For our nation's survival we must reform healthcare in this country soon. Uninformed legislators who worship at the idol of capitalism are not going to generate this reform, but neither are those who would give overpriced healthcare to all without serious quality and efficiency improvements. I would not recommend this book to ordinary patients; however, some bold nurse or patient might want to write another book with a slightly different title: Partners in Health: How Physicians, Hospitals, **Nurses, and Patients** Can Be Accountable Together. About $37 from http://www.amazon.com/Partners-Health-Physicians-Hospitals-Accountable/dp/0470550961#_

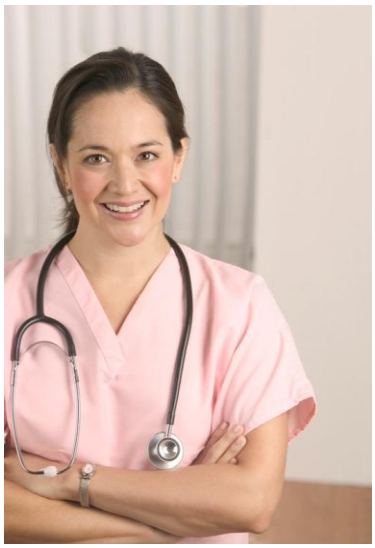
## *Power to Nurses*

Many of my colleagues involved in patient safety are outspoken and frustrated nurses. They have thoughtful ideas for improvement of healthcare, but their central theme seems to be to increase the nurse-to-patient ratio in hospitals. They tell chilling stories of tragedies from understaffing.

This month a report was published by the Institute of Medicine (IOM) calling for an increase in the responsibilities and numbers of nurses in healthcare.[1] The increases should come at the level of care delivery on the hospital floor as well as at meetings of those who would redesign healthcare. There should be more 'advanced practice' nurses, which constitute only 10% of the 2 ½ million nurses now practicing. Creating and advocating post baccalaureate nursing education should be a target for improvement. More nurses with advanced degrees should help ease the shortage of nursing school faculty.

In many situations nurses have been shown to provide the same quality of care as physicians. The IOM points out regulations at the state and federal level need to evolve to allow the expanded roles proposed by the IOM for nurses. More residency programs are needed to help nurses first entering the workforce. Finally, nurses need more opportunities to practice as members of multidisciplinary teams.

Who do you suppose might oppose such reasonable recommendations? Two organizations already opposed are the American Medical Association and the Academy of Family Practitioners – that should be no surprise. They oppose expanding nurses' scope of practice on grounds of safety risk. Doctors, they assert, are so much more educated and trained than nurses. Certainly knowledge is an important aspect of delivering quality care, but so is taking time to listen to the patient's needs, taking a good history, and 'knowing' the patient as a human being.



In my opinion, a gradual, thoughtful expansion of the role for nurses could improve patient safety ***and*** reduce medical costs. Safety gains would come in improved nurse-to patient ratios in hospitals and cost reductions would come from nurses doing work that other caregivers now get paid much more to perform. Doctors and hospitals just need to get onboard by recognizing nurses as full partners in the healthcare team.

## *Do You Have a Right to Health?*

Last month I reviewed a book by Tom Reid in which he noted that we are the only developed country that fails to recognize the moral imperative that everyone on our soil has a right to decent healthcare. A related commentary written by a lawyer and a physician appeared this past month in

the *JAMA*.[2] The lawyer's side of the issue notes that the international community has affirmed the ***legal*** imperative that the right to health is inalienable. Beyond this it is also a ***moral*** imperative that seems to be pushed aside in America. However, the authors point out that about three-fourths of us recognize that healthcare should be a human right. More than 100 countries have placed the right to health or healthcare into their constitutions. Yet the United States has failed to adopt the right to health and healthcare as either a legal or moral imperative. Our government must find a way to ensure the availability, accessibility, and quality of healthcare. Private enterprise has failed us.

The authors decline to point to a single cause of this failure. Perhaps it is our view that the individual must deal with his own health and healthcare, or that exceptionalism makes us opposed to international laws mandating adequate healthcare. I would postulate that only in America is so much money being made by the healthcare industry that any imperatives, either legal or moral, are subordinated to the greed of the industry.

I note with some pleasure and disappointment the authors' observation that in 1944 President Roosevelt's State of the Union address called for a second bill of rights – 'rights to adequate medical care and the opportunity to achieve and enjoy good health.' Of course medical care in those days had not become super-expensive. The president suffered from polio from the age of 39 and would be dead within 15 months of his speech. His dream remains unfulfilled. I regret that his vision of the right of everyone to quality healthcare never had a chance to come alive.

FDR standing 8 years after polio struck him

The authors recognize that our nation must build on the Affordable Care Act to achieve Roosevelt's vision and place us among the vast majority of nations that observe the right to decent healthcare. It will take much political and moral courage to join those nations.

## *$ Spendthrift Doctors $*

One of the tenets of being a 'good' doctor is careful stewardship of resources. This stewardship requires thorough and up-to-date knowledge. I have often voiced my opinion that many doctors do a poor job of keeping up with new medical information, which I recognize is not easy to do. The next great medical information explosion is going on right now; it is called genetic medicine. In order to help non-expert physicians make wise decisions about genetic testing for their patients, national guidelines have been written by experts to foster evidence-based care. Like a great many medical guidelines, these guidelines are not being understood and followed.

A geneticist at Baylor College of Medicine in Houston named Sharon Plon and her colleagues have just published an on-line paper in *Genetics in Medicine* reporting that they asked 225 Texas physicians in various specialties what kind of genetic testing they would order for healthy women in their early 40s who had a relative with breast or ovarian cancer who had undergone genetic testing already.[3] The results of that relative's genetic testing were presented to the doctors in various ways. Essentially, if the relative with cancer had mutations that raise cancer risk, then the first degree relatives should be tested only for those specific, single-site mutations. They do not need a comprehensive test.

The doctors far too often chose the comprehensive testing, which typically costs about $3,300, whereas the guideline-recommended testing typically costs only $500. The authors wondered if the physicians understood the guidelines for this type of genetic testing. They note that only 2% of the doctors followed recommended testing in all the cases presented. Dr. Plon noted that in other countries consultation with genetic professionals is required. In the United States the perception of increased cost has kept this from becoming a requirement; however, her findings suggest that consulting a professional geneticist would actually save money.

Personally, doctors should be learning how to find guidelines for genetics testing and use those guidelines in their patient care. If they are not going to do that, then they do need to engage a genetics professional. Doctors have got to start knowing what they don't know and caring for their patients

accordingly. Please read the next article to receive further evidence of the need for improved physician training.

## *Erroneous Echocardiography*

I usually do not report on information outside peer-reviewed journals, but I'm going to deviate here because the information I'm going to report on was given at a meeting of The American Society of Echocardiography by a physician with good credentials.[4] She set out to determine how accurately her colleagues in the hospital where she worked were interpreting echocardiograms.

Her investigative team reviewed 235 echocardiograms performed in Aurora St. Luke's Medical Center near Milwaukee between August 2007 and October 2008. They found that almost 30% of the echocardiograms were misread. The echocardiograms were read by 35 different cardiologists, only 3 of which had top level (level 3) training.

At least five of the patients with misread echocardiograms were headed to the operating room when the error was discovered, another 18 were subjected to invasive echocardiography using a throat probe, and 19 underwent invasive coronary angiography. Obviously, healthcare cost for these were passed on to the patient.

Having heard of these results, a cardiologist and assistant professor of medicine from Harvard Medical School commented, "There are an awful lot of people out there interpreting echocardiograms who really shouldn't be." The lead investigator, Kiran Sagar, MD added, "If you randomly sampled another hospital in, say Montana…you'd probably get the same result." By the way, Dr. Sagar has been fired by Aurora St. Luke's Medical Center.[5]

The message here to patients is that getting high quality care for your heart can be a challenge. **Ask about the credentials of those who would evaluate and invade your heart**. Cardiologists that were board certified before 1990 were certified for life with no requirement to demonstrate competency to their board. Few do voluntary maintenance of competency. **Ask for a second opinion if there is any doubt about your physician's credentials and your diagnosis.** One of my colleagues in patient safety, a dentist, has declared that she would never trust her heart to a cardiologist without a second opinion.[6] There is a lot of danger with careless cardiology and the consequences can be lethal. I know.

References


1) Kuehn, BM. IOM: Boost nurses' role in health care. *JAMA* 304:2345-2346, 2010
2) Freidman, EA and EY Adashi. The right to health as the unheralded narrative if health care reform. *JAMA* 304:2639-2640, 2010
3) http://www.bcm.edu/news/item.cfm?newsID=3286
4) http://www.jsonline.com/features/health/96945709.html
5) http://www.jsonline.mobi/features/health/113541984.html?ua=blackberry&dc=smart&c=y
6) Hallisy, J. *The Empowered Patient*. Bold Spirit Press, 2008
7) Moellering, RC. NDM-1 A cause for worldwide concern. *N Engl J Med* 363:2377-2379, 2010


Answer to question this month: c) 50 years ago[7]

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