PSA

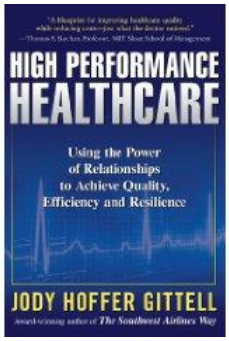
Patient Safety America Newsletter

November 2009 http://PatientSafetyAmerica.com John T. James, Ph.D.

Answer to last month's questions: d) Michael Jackson's cardiologist administered Propofol to him just before he died, and b) Anna Nicole Smith was prescribed many drugs including Dilaudid , which is known as "hospital heroin."

BOOK REVIEW:
High Performance Healthcare
By Jody Hoffer Gittell

This book was written for the leadership staff of hospitals in America where one could argue that too often the healthcare delivered is anything but "high performance." For the rest of us, physicians, nurses, and patients alike, this book provides an interesting look inside what ails hospitals in America and how team building through "relational coordination" can improve performance. The author seems to have impeccable academic credentials. She presents various aspects of what she discovered as she and her colleagues investigated the practices of team-building in nine hospitals in three states – New York, Massachusetts, and Texas. She is recognized for her previous studies of the effective workings of Southwest Airlines.



I like this book because it is systematic, it uses quotes from those on the front lines of hospital care, and it gives me new insight into why hospitals often struggle to build effective care teams. The author gives positive reviews of hospitalists as physicians able to improve outcomes and efficiency. On the other hand, this book disappointed me because it generally overlooks the most important member of the healthcare team – the patient (or patient advocate). I understand that the patient is a "transient" member of the healthcare team, but overlooking the patient's crucial input seriously weakens the prospects for creating high performance healthcare. Hospital care is unlike any other industry. The product itself (a healthy person) is part of the team producing the product.

In some ways this oversight can be forgiven because the patient is traditionally overlooked as a competent, motivated, and integrating member of the team. Some of the author's research involves patient surveys after discharge, but this is not the same as real-time involvement as an inpatient.

There was one subchapter in which the relational coordination of the primary care physician (PCP) and the informal caregiver (a patient's family member) was compared. The author states that "the PCP was the least well connected, exhibiting low levels of relational coordination with everyone, including the family member or informal caregiver…The only participant who played a consistent system integrator role across the continuum of care was the informal caregiver, the family member of the patient." Then Ms Gittel explains, "We also found that integrating family caregivers into the care team made a positive difference."

Another factor missing, it seems to me, is a chapter on the response of the team when a serious medical error has occurred. Teams in all settings make mistakes all the time, but those mistakes seldom lead to suffering and death as they do in hospitals. How should the team discover, acknowledge and learn from medical errors when they occur? How should the team respond to near misses and hospital-acquired infections? How should errors be communicated to the patient or the patient's survivors?

One of the most interesting chapters to me was the last one in which the author surveys barriers to implementing high-performance healthcare in hospitals. You have seen this when your medical bills come in after a hospital stay.

Physicians bill you separately from the hospital because they *are* separate and legally distinct from the hospital. The fundamental reasons for this separation seem to be physicians seeking autonomy and hospitals being happy to grant that because they are less vulnerable to a lawsuit if the physician makes an error. As long as the hospital does not supervise the doctors practicing there, their legal liability is much less. Obviously this works against team building. In all, I think this is an informative read even for average patients, although the tables take some digesting to interpret. On balance, I'll give it 4 stars out of 5.

Targets for Change in Healthcare Reform

Three thoughtful articles in the *New England Journal of Medicine* describe strategies for intelligent, courageous, and genuine reform of American healthcare. The first is entitled "Doctors as the key to Health Care Reform."[1] Here a physician from the Harvard Medical School characterizes the critical position doctors occupy in reform. His proposition to his colleagues is that the fee-for-service basis by which most physicians are paid must become history.

He describes how fee-for-service medicine leads to maximization of the services doctors provide and to overuse of new and more expensive technology. Furthermore, monetary incentives lead to more young doctors into becoming specialists since they can make more money. The author's judgment is that the reform proposals on the table fail to address the perverse incentive of money. I agree.

I just returned from a professional meeting involving engineers and scientists. One expert reported that high-school students were asked what career they wanted and why. They wanted to become doctors, not engineers or scientists, so they can make more money. Perhaps the sickness in American medicine has deep roots in our malignantly materialistic society.

The physician author describes his proposal for a national system of community-based, multi-specialty, doctor-managed group practices. He lists similar systems now in existence, including the Mayo Clinic. These clinics would be supported by taxes and physicians would be salaried to avoid the overuse of discretionary procedures. The groups would compete for patients who would have access to trusted ratings of the quality of the group practices. Ideally, this would leave healthcare decisions between the physician and patient.

The author states that "the majority of the public, the medical profession, and the business community would have to unite in advocating this change…or the current slide of the system toward bankruptcy will continue." I would add that this approach could only work if the public does not see it as socialized medicine and if patients are ultimately in control of the priorities. Patients would need to be on an equal footing with physicians through a patient bill of rights to engage in informed decision-making.

A second perspective article entitled "Getting Past Denial-The High Cost of Health Care in the United States," provides data that I feel would support the conclusion of the first author.[2] The writers assert that "we should be able to eliminate wasteful and unnecessary [medical] services." They use data from the Dartmouth Atlas to show what some might suppose is obvious: people in better health spend much less on healthcare and low-income people spend more because they are less healthy.

The authors show that discretionary spending elevates the per-patient cost in many geographical areas because the care is "more intense." More intense care does not lead to improved outcomes for patients. In fact overzealous admission to a hospital can place the patient at risk of acquired infection and debility. The authors assert that "so much discretionary care is provided in the United States that we could easily afford to expand coverage without increasing taxes or rationing care."

In a third perspective article three experts argue that the FDA must start adding information on comparative effectiveness of the products it approves.[3] If the FDA did this, patients and their physicians could compare the costs and effectiveness of a drug with other drugs targeted to

the same illness. As it is, labels only indicate that a drug is effective compared to no treatment. Such information comes from placebo-controlled studies.

The writers argue that "active-comparator" studies are needed to determine the *relative* effectiveness of a drug compared to an existing standard drug. Since new therapies tend to be more expensive than older ones, patients and physicians could decide if any gain in effectiveness is worth additional costs. If no such research has been done, then the drug should have a label indicating that the drug may be no more effective than older alternatives.

There is a lesson for you in these ideas. First, if you think your doctor is selling you discretionary treatment or prescribing a drug that has not been shown to be more effective than older alternatives, ask tough questions about how he knows the proposed treatment or drug is better than simpler and less expensive alternatives. You may want to review the story I wrote last month about overuse of expensive scanning techniques in older adults who faint when a simple and inexpensive test that has been around for decades, the postural blood pressure test, is much more effective and much less expensive.

Your Doctor as Your Partner

An editorial by two MDs in the *Archives of Internal Medicine* deals with how a physician ought to create more patient-centered care in his practice.[4] Factors that contribute to patient-centered care include use of the best-available knowledge, support of patients as they make decisions, and advocating systems that address the needs of the patient during treatment and recovery. The authors assert that "high quality decision making is not taking place in the current health care system…and poor communication between physicians and patients have been documented across a wide range of diseases."

One way to improve both of these deficiencies is the use of decision aids. The authors describe such an aid for decisions involving which drug to use for management of diabetes. This aid was deemed beneficial to both patients and physicians. To encourage and assess the engagement of the patient in his own decisions, the authors propose that feedback be sought on the whether the patient had adequate knowledge and whether the decision reflected the patient's values and preferences. Often this could be a decision for "less intense" care, which may avoid the over utilization of testing and intervention that is the hallmark of healthcare in some parts of the country.

The message for you as a patient is to gently insist that you have adequate knowledge of your choices of treatment and that you have had time to weigh the choices based on how they are likely to affect your lifestyle.

Move It or Loose It

An investigation of physical activity in "very old" people living in Jerusalem has found that physical activity and longevity are strongly associated.[5]

Nearly 2000 people, born in 1920 and 1921, were studied. Each participant reported their level of physical activity using a questionnaire, and the final discriminate between sedentary and physically-active was whether about 4 hours of physical activity was done each week.

At the age of 70 years, the 8-year mortality for active and sedentary people was 15% and 27%, respectively. At the age of 78 years, the 8-year mortality for active and sedentary people was 26% and 41%, respectively. At the age of 85 years, the 3-year mortality for active and sedentary people was 7% and 24%, respectively. The authors examined the question of increased risk to health caused by physical activity and concluded that there was no evidence of such an effect.

The authors point out that 77% of their study population fell into the physically active category at the age of 78 years. This is a higher percentage of active individuals than in the same age group in North Americans. They also

concluded that starting physical activity was beneficial to increasing one's life expectancy. **Whether you are in this very old age group or not, beginning physical activity is likely to increase your healthy life expectancy.** If you have any serious health limitations, discuss your action plan with your doctor. And then, move it!

Get with the Guidelines!

Two scientific studies and an editorial in the *Archives of Internal Medicine* underscore the importance of following guidelines for antibiotic therapy in older folks with community-acquired pneumonia (CAP). The first study involved 1650 patients aged 65 years old and older admitted to a hospital for treatment of CAP.[6] The study group was divided into three groups according to whether the 2007 guidelines from The Infectious Diseases Society of America and The American Thoracic Society were followed. Those groups consisted of people who were under treated, those who were treated according to guidelines, and those who were over treated.

The investigators looked at several outcome parameters; however, for our purposes we will consider only in-hospital mortality. The mortality in patients who received treatment according to national guidelines was 8%, whereas the mortality for patients who were under or over treated was 17%. If you or someone you care about is being treated for CAP in a hospital, insist that a national guideline is followed in their antibiotic therapy; it could save a life that matters to you.

In a parallel study, involving records from 55,000 inpatients with CAP treated at 113 community hospitals, a team of investigators asked whether antibiotic therapy given according to guidelines improves health outcomes.[7] Most (65%) of the patients had received guideline-concordant therapy. Those that received this therapy were less likely to die during their hospital stay (odds ratio 0.70) and their average hospital stay was 0.6 days less than the group that had not been treated according to guidelines.

A physician-commentator placed these studies in perspective of the overall database on the value of using guideline-concordant therapy to treat patients with CAP.[8] There is by no means 100% agreement among doctors that these guidelines ought to be followed; however, these studies "add to the growing body of robust evidence supporting guideline-recommended antibiotic regimens in patients hospitalized with CAP." All potential confounders in these studies were not rigorously controlled; however, the editorialist asserts that no confounder he could think of could account for the large reduction in mortality associated with guideline therapy.

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Seven years ago, after a scathing series of stories in the *Dallas Morning News*, the Texas Medical Board promised to crack down on bad doctors. Patient endangerment would be dealt with severely. And sexual misconduct, one official said, "would become a thing of the past. It hasn't turned out that way.

Brooks Egerton, October 11, 2009, The Dallas Morning News