



Patient Safety America Newsletter

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Question: Two physicians commenting on hand hygiene in the JAMA cited a recent study showing that hand hygiene compliance before patient contact in hospitals is:

- a) 10%*
- b) 20%*
- c) 30%*
- d) 40%*
- e) 50%*

Mistakes in Your Outpatient Care

Have you ever thought that a serious error was made by your doctor during your care as an outpatient? If you have, then you have plenty of company as evidenced by a scientific study published this past month in the *Archives of Internal Medicine*.¹ The investigator team, which included three MDs, questioned patients from seven primary care practices serving adults in 2008. Almost 1700 patient participants were asked if they had detected a mistake in the care given to them by their doctor.

This is an important study for several reasons; the first is that the knowledge of patients about their care was systematically sought by medical doctors. The second is that many more of us experience outpatient encounters with physicians than experience in-hospital stays where most studies of patients' opinions originate. The third important facet of this study is the astounding findings that almost 16% of the patients remembered at least one medical mistake in the past 10 years of their outpatient care by physicians.



Let's look a little closer at the study and findings. The study population included adults evenly distributed in age from 18 years old to more than 60 years old. They lived in urban and rural areas of North Carolina and spoke either English or Spanish as a primary language. A third was white, a third was black, and a fifth was Hispanic.

Health problems included high blood pressure, depression, chronic back pain, and type-2 diabetes.

Wrong diagnosis and wrong treatment were the most common mistakes. Fourteen percent of the patients changed doctors as a result of the perceived mistake. The rate of perception of mistakes increased with higher educational level and poor physical health. The severity of harm was divided into 5 categories ranging from 'none' to 'severe.' About 43% of those patients reporting a medical mistake indicated that it caused 'a lot of harm' or 'severe harm' to them.

The authors suggest that some of the errors perceived may be a mistake in perception (i.e. communication) rather than a true technical mistake on the part of the physician. Their attention appears to me to be focused on physicians' need to ensure



patients do not perceive mistakes so that the physician to patient relationship is maintained (i.e. the patient does not change doctors). To me these findings suggest a patient-centered way to collect information about the performance

of specific physicians so that patients seeking high quality care can compare doctors as seen through the eyes of their patients. I would think that such data would also be useful to medical boards when they consider renewing the license of a physician.

Two MDs wrote a commentary on the study summarized above.² They point out from other studies that one third of Americans believe that they or a family member has experienced a preventable medical error and one fifth of these caused serious

health consequences. In out-patient settings the opportunities for error are manifold. These include doctor-to-doctor communication problems, opportunities for error with multiple medications being prescribed, step-wise diagnostic practices that lead to delays in diagnosis, and the shortage of primary care physicians leading to delayed appointments. They note that the medical community “can no longer accept inadequate knowledge about the safety of ambulatory care, and we must be able to show the general public how well we are progressing toward providing safer and higher quality health care.”

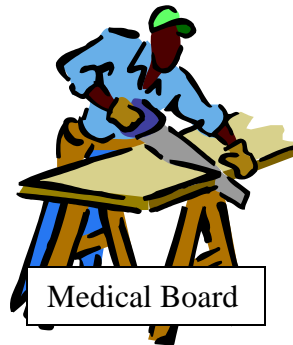
A perspective article in the *New England Journal of Medicine* this past month echoes and expands the observations made in the commentary cited above.³ Two MDs write about ‘Patient Safety beyond the Hospital.’ They note that missed or delayed diagnoses are the most common cause of malpractice claims from out patients. The current emphasis on reducing hospital readmissions has put more of a burden on out-patient care, yet 2/5 of hospital patients have pending medical test results at the time of discharge, and the results are often not communicated to the patient’s primary care doctor. The risk continues to rise as more complex procedures are undertaken in outpatient settings. Significantly, the authors point out that many clinicians have overlooked an important abnormality in laboratory results that was pointed out to them by the patient.

Until outpatient safety and quality of care are rigorously monitored and you have access to that data for specific physicians, you are in charge of quality control for your outpatient care. Ignoring this responsibility will put you directly in harm’s way.

Physician Quality and Public Information

You are really ill for the first time in your life and you need to select a high quality primary care physician to diagnose and treat your condition or direct you to the appropriate specialists. You have heard good and bad stories about several of the doctors in your area, but you want more reliable data to make your selection. Where can you get this information?

An article entitled “Associations between physician characteristics and quality of care” set out to determine the relationship between information you might be able to learn about a doctor and the quality of care they deliver to their patients.⁴ The performance scores of more than 10,400 Massachusetts physicians was assessed using 124 quality measures from the RAND quality assessment tool. The mean performance score was 62.5%, which is poor on most grading systems.



Furthermore, Massachusetts is known to have higher overall quality than the average for the United States.

None the less, can we at least have data that will allow us patients to select for the best doctors out there? The study’s answer, unfortunately, is ‘not really.’ Three characteristics of doctors that are typically available to patients were found to be associated with better quality performance, but the performance improvement was not remarkable. Graduation from an American medical school compared to a foreign one increased the score by 1%. Women doctors did 1.6% better than men doctors, and board certification increased the quality score by 3.3%. Interestingly, there was no association between malpractice claims or disciplinary actions and quality of performance. MDs and ODs fared the same. Women doctors did especially well on measures of the quality of preventive care.

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Genetic Testing Snake Oil

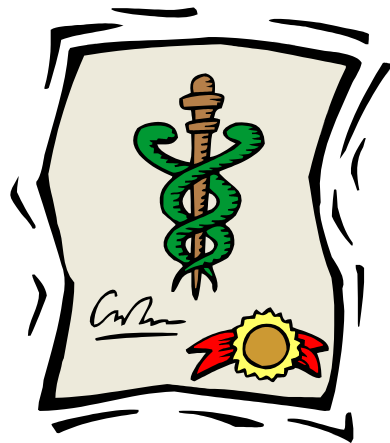
Your family seems to have more cancer and heart disease than most others and you are getting older and are beginning to fear that you may fall victim to some form of cancer or heart disease. Can genetic testing help you know if you have an increased risk?

A perspective article by Bridget Kuehn in the *JAMA* provides a cautionary warning regarding such testing, especially of the direct-to-consumer variety.⁵ Just for fun you might want to surf the internet for genetic tests you can directly purchase.

Ms. Kuehn writes about the results of a Government Accounting Office probe of the efficacy of such testing. That office bought test kits from four companies and sent samples from five individuals. Most of the donors (80%) received results from the companies that were inconsistent with their medical conditions. Members of the investigation team and expert consultants noted that the results were of little practical value and that most studies show that genetic markers add little to the

traditional markers of risk such as family history.

The most troubling finding was that of the 15 companies engaged in genetic testing, 10 were found to exaggerate the value of their tests to the point of fraud or at least deception.



Clinicians were cautioned that when a patient asks about the results of a genetic test he obtained from a direct marketing company, the physician should refer the patient to a genetic counselor.

Screening for Breast Cancer

We all know of women who have fought a battle with breast cancer and sadly some have lost that battle. Others have won the battle, but often at the cost of unpleasant treatments and years of fear of the disease returning. You are no doubt aware of the recent controversy over the age at which screening for breast cancer should begin: Is it at 40 or 50 years of age?

If that controversy were not sufficiently troubling, a study published in the *New England Journal of Medicine* on 40,000 Norwegian women diagnosed with breast cancer between 1986 and 2005 concludes that biennial mammography screening in the age group from 50 to 69 years reduced mortality by only 2.4 deaths per 100,000

person years.⁶ By comparing historical groups to recent screening groups, the authors concluded that a reduction of 4.8 deaths per 100,000 person years was due to optimized care by multidisciplinary teams formed to treat women with breast cancer. Screening matters, but optimized care saves the lives of more women.

To what extent do women have access to optimized care in the United States? In my opinion, the investigator's concluding remarks are critical of the U.S. healthcare industry. They state: "The apparent benefit conveyed by optimized patient care may be missed unless breast-cancer screening is integrated into a *well-functioning health care system that is available to the entire population.*" [Italics mine] It is impossible to make the case that the healthcare system in America is either "well-functioning" or "available to all."

The findings reported by the Norwegian investigators may not be directly applicable to breast cancer in women living in the United States. Post menopausal women who are obese have 1.5 times the risk of breast cancer as women of healthy weight.⁷ Experts have estimated that about 15,000 deaths per year from breast cancer could be eliminated if American women maintained a healthy weight.⁷ About 8% of Norwegians are obese, whereas 31% of Americans are obese.⁸ Thus, it is likely that screening might be more effective in American women than in Norwegian women. Obesity does reduce the effectiveness of detection of breast cancer.⁷

A commentary on the Norwegian study captures the down side of too much screening.⁹ The author, an MD expert in public health, notes that over 10 years 2500 women over 50 would have to be screened to prevent one death, but what happens to the other 2499? As many as 1000 will have at least one false alarm, of which half will undergo biopsy. Due to over diagnosis, between 5 and 15 women will be needlessly treated with surgery, radiation, and/or chemotherapy. The author thinks that the availability of breast cancer screening is important, but it should be dropped as a measure of quality of



our healthcare system. *Informed* women should be making the decision about their need for screening. The informed choice is not easy.

Who is Worthy of Board Certification and Your Trust?

Most of us would prefer to see a board-certified specialist when being diagnosed and treated for a potentially serious illness. Board certified specialists do somewhat better than their uncertified counterparts in meeting quality measures of physician performance.⁴ One of the key elements of board certification is maintenance of certification (MOC). Specialists certified before 1990 do not have to participate in MOC to remain board certified, and most do not. In the majority of the 24 specialties recognized by the American Board of

Medical Specialties (ABMS), periodic MOC is required if the doctor is not grandfathered, that is, certified before 1990. One element of MOC is called the 'secure examination' in which

the technical ability of the doctor is assessed. As you might imagine, periodic examinations are not welcomed by some specialists after they have passed an initial examination.

A commentary in the *JAMA* defended the worth of this examination as it is now given to doctors participating in MOC.¹⁰ I thought the defense of this examination was well presented. The authors point out that individual physicians are not skilled at identifying their knowledge gaps, so a general examination makes sense. Should the examination be open book? No, say these authors because most physicians make clinical decisions based on their memory rather than digging through medical literature to discern the best patient care. One of the medical boards is considering allowing physicians limited access to some resources during the examination.



No examination is perfect in discriminating those who should be recognized as board certified specialists and those who should not be. Public expectations are that a board-certified specialist has a higher skill level than a non-certified specialist. I believe that the secure examination is a valuable tool in meeting this expectation. I believe also that allowing grandfathered specialists to represent themselves as board certified without meeting MOC criteria such as passing the secure examination leaves patients at higher risk of misdiagnosis and treatment. The boards associated with the ABMS should distinguish for the public those doctors who complete MOC and those who do not. Not long ago a national study showed that ¾ of cardiologists had not been assessed for competency in the past 3 years.¹¹ If your specialist received his medical degree a few years before 1990, you may want to ask if he participates in MOC. Your life could be in his hands.

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Answer to question this month: b is the best answer; it's 21% compliance¹²