PSA

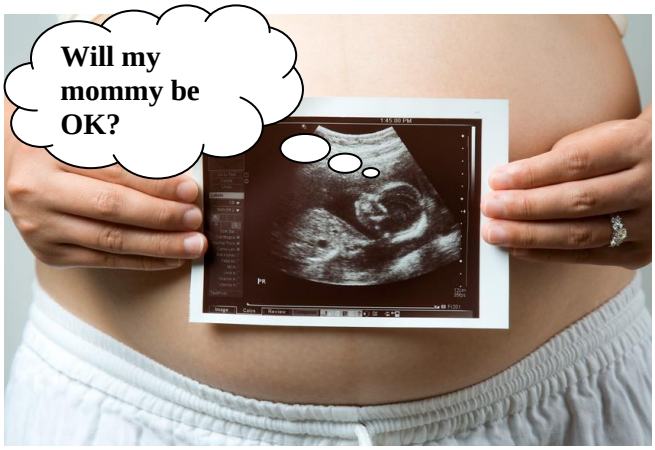
Patient Safety America Newsletter

September 2014 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: On average, how much cost is associated with an American physician filling out insurance company paperwork each year?*
a) $10,000 b) $20,000 c) $50,000 d) $80,000 e) $110,000

Complications from Childbirth

Having delivered a baby in a hospital, most women expect to go home being healthy and feeling well, if a bit overwhelmed by their new responsibilities. A team of eight specialists studied a sample of 750,000 deliveries in 2010.[1] They began by dividing the hospitals into three quality categories based on the rate of serious obstetrical complications. By "serious complications" the investigators meant maternal hemorrhage, laceration (vaginal delivery) or operative complication (Caesarean delivery), infection, or others including complications from blood clots. There are about 4 million deliveries each year in the US, but according to this study, 13 percent of those deliveries, involving roughly a half million women, produce at least one serious complication. This is startling.



The investigators found something else startling: the rate of complications varied 5-fold from the low-quality-hospital group to the high-quality-hospital group for Caesarean delivery and more than 2-fold for vaginal-delivery groups. In addition, the infection rate for average hospitals was 4-fold higher for Caesarean deliveries than for vaginal deliveries.

The investigators used a national, inclusive administrative databased to discover these complications. The authors noted the limitations of using administrative data, which can vary in accuracy from hospital to hospital. They also note that there is no nationwide, publicly available reporting system for such complications.

Those who pay taxes will be interested to know that Medicaid paid for 48 percent of births in 2010, reflecting the fact that taxpayers also picked up almost half the bills for treatment of complications. The authors noted another study that found a 10-fold variation in the rate of Caesarian deliveries in American hospitals. They called for comprehensive metrics for the quality of obstetrical care, noting that "report cards" involving quality metrics have in many cases led to quality improvement. **Such report cards should be publically available to guide the choices women make in selecting a hospital for giving birth. There are huge differences.**

Copy and Paste in Medical Records

Almost everyone who has used a computer to generate a document has used the "copy and paste (C&P)" functions to save time and effort. Saving time and effort is paramount in hospital settings, so C&P is often used by physicians to create portions of medical records. There is nothing inherently wrong with this; however, it can lead to undesirable consequences. Two MDs and a JD gave their views on C&P in electronic medical records.[2] They first note that the Office of Inspector General of the Department of Health and Human Services has declared that safeguards against misuse of electronic records are deficient, creating opportunities for fraudulent records.

What are the "opportunities" for misuse of medical records when C&P is easily performed? Records may actually be wrong when inaccurate material is pasted into a patient's record. Another potential misuse is created because physicians and hospitals get paid for the number of procedures performed, so over-documentation is a temptation. The writers note that as of January 2013, only one-fourth of hospitals had a policy on use of C&P.

The rules on C&P should include the following: no C&P prior to the procedure, no C&P from one patient's record to another's, give proper attribution when information is used from another provider, and only procedures actually performed for a specific patient can be subject to C&P.

I would argue that if hospitals would invite hospitalized patients or their advocates to review their medical records each day, the opportunities for misuse of C&P could diminish. **Once again the patient has a significant role in solving an important problem, but the medical industry seems reluctant to let the patient into the realm of medical record creation…it is a sacred place where only physicians can ply their wares.**

C diff and Antibiotic Overuse

Many treatments in medicine involve "walking the thin line" between recovery and harm. One important example of that was described by and MD in the "Less is More" section of the *JAMA Internal Medicine* in August.[3] The physician

describes an elderly patient with an arm injury that has resulted in necrotizing fasciitis, requiring treatment with three antibiotics that initially lasted 21 days. Upon cessation of the treatment the woman developed fever and watery diarrhea, and she tested positive for *C diff*. Despite additional antibiotics the woman's condition deteriorated and she died after her family declined surgery for mega-colon.

The writer asks the appropriate question: Was a 21-day treatment with the variety of broad spectrum antibiotics necessary to manage the necrotizing fasciitis? Obviously, this condition required treatment, but possible overtreatment of the infection may have actually led to the death of the patient due to *C diff* infection. If you are advocating for a patient with a serious infection (*not C diff*), ask about the rationale for antibiotic treatment: Is the antibiotic specific for the infection involved and is the length of treatment appropriate? Generally, 5-10 days of treatment is necessary to resolve an infection if the antibiotic is going to be at all effective.

The Allergy Treatment Trap

Rosemary Gibson, a colleague of mine in the patient safety movement, coined the term "Treatment Trap" to signify conditions in which the patient is given too much "treatment" in the face of faulty testing.[4] A fine example of this was described by two doctors in the perspective section of August's *JAMA Internal Medicine*.[5] They describe the case of a 4-year old boy taken to an allergist to discover the food allergy that his mother thinks is causing his attention deficit hyperactivity disorder (ADHD). The testing included an IgG test that falsely showed an "allergy" to many foods.

The mother progressively removed various foods from his diet with no reduction in his ADHD. In fact the appropriate test for allergy, which is not associated with ADHD, is to do an IgE test specific to the suspected food allergy. The boy had no real food allergies. Except for prolonging the mother's concern, subjecting the boy to the unpleasant experience of a blood draw, and making the boy cranky because he could not have some of his favorite foods, there was not much harm done. Ultimately, it was recommended that the mother seek professional advice on how to manage ADHD.

There are a couple of lessons here for patients. Make certain you understand the rationale for any allergy testing you have requested on your child. And make sure that the testing is focused on a limited number of specific possibilities.

Physician Morale and Changing Politics

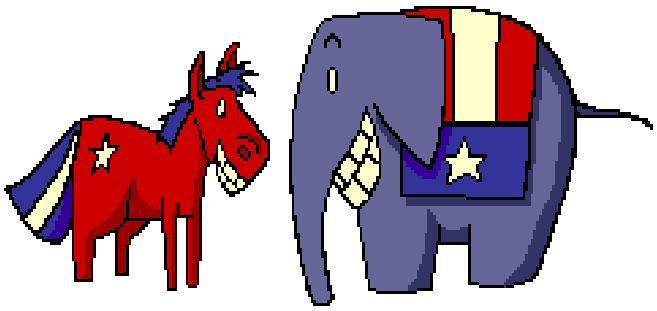
I don't know about you, but I want my doctor to be a person who is happy with their career choice. Their attitude is at the core of patient safety, yet the vast majority of physicians in America are not happy with their choice of medicine as a career according to a story published in the *Wall Street Journal* at the end of August.[6] According to the article, in a survey conducted in 2008 only 6% of doctors characterized their morale as positive. One emergency room doctor, having opined that he gets no respect from those he works with, observed that in the ER he is expected to order wasteful tests and this "really sucks the love out of what you do." He declared that he feels like a money-making pawn for hospital administrators.

According to the writer of the article, Sandeep Jauhar, MD, part of the solution lies in bundled payments rather than fee-for-service payments. The emphasis on the needs of patients needs to take precedence over the business models designed to maximize profits. As the good doctor opined, "The American system too often seems to promote knavery over knighthood."

In my opinion, patients have a role in improving physician morale. Here are my thoughts on patient engagement to improve doctor morale: 1) no matter how much research you have done, always treat the doctor's opinion with respect, 2) ask questions respectfully making it clear that you are addressing your fears and not his competence, 3) when the outcome of your care has been positive, write a letter or card to the doctor thanking him for healing you, and 4) share positive stories of physician care with your friends.

At a bigger-picture level, I would like to see the Centers for Medicare and Medicaid Services require each hospital to provide a randomized survey of physician and nurse morale and make the results for each hospital available to the public. I am much more likely to choose a hospital where 85% of doctors have high morale than one where only 15% do.

A research article involving the political contributions of physicians at the federal level caught my eye this past month. The investigators asked what portion of federal contributions went to Republicans over the years from 1991 through 2012.[7] Over this time, the contributions of physicians increased from $20 million to almost $190 million. Physician contributions to Republicans were over 50% except in 2008 and 2012, and a higher percentage of men contributed to Republicans than women. For example, in 2008 the men's percentage was 50%, whereas the women contributed about 20%.



A most interesting observation in the article involved the correlation of physician earnings with their propensity to contribute to Republican election campaigns. For example, 75% of orthopedic surgeons, earning about $600,000 per year on average, contributed to Republicans, whereas less than 25% of various types of pediatricians, earning about $200,000 per year on average, contributed to Republicans.

In an invited commentary on the political research above, an MD made several observations.[8] He notes that female doctors tend to favor the Democrat party and that the portion of women doctors is growing. Perhaps this will lead to a more equitable healthcare industry; however, the entities that profit from the current commercial system are not likely to step aside easily. He sees a growing awareness in America for more fairness in access to quality healthcare and other social benefits. In Texas I do not often see such awareness.

Overuse of Coronary Artery Stents

An expert commenting on an article on high-tech-guided stent placement went on to discuss the lack of value of *any* stent placement in many patients with stable heart disease.[9] He called this the "elephant in the room," because regardless of the nature of the stent, there is often no need for *any* stent – high-tech or otherwise. Optimal medical therapy is the treatment of choice for stable coronary artery disease. He points to studies showing that nearly half of all stents are unnecessary, costing the healthcare system about $2 ½ billion per year. I would point out that most of this cost is borne by the taxpayer through Medicare, which tends to blindly pay for just about anything. The writer recommends

that the cardiologist who wants to sell a stent to his patient that does not need one must be required to tell the patient during the consent process that the stent will not offer any benefit in management of stable angina over optimal medical therapy alone. Furthermore, the writer asserts, there is a 1% risk of heart attack, stroke, or death when a stent is inserted. I have seen studies using sensitive measures of "heart attack" that find a much higher percentage of "heart attack" from stent placement.

In the face of stable heart disease, if your cardiologist recommends a stent for your coronary artery narrowing, you must ask a lot of questions before allowing this invasion of your body. A second, independent opinion would be in order.

Hospital Quality Reporting

There are many complication involved in creating a fair system for reporting of hospital quality. An opinion paper explores one of these – the differences in the socioeconomic status (SES) of the patient population served by each hospital.[10] In 2003 the Institute of Medicine published a book entitled "*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*." The viewpoint writers assert that there has been little progress in reducing such disparities. Then they ask if it is fair to place all hospitals on the same quality metric scale when the populations they serve are quite different.

Correcting for SES differences is not straight forward. I would send the reader back to the first article in this newsletter where huge differences in obstetrical performance were noted among hospitals. How much of this is due to SES differences in the populations served? My purpose in pointing all this out is to communicate that ranking hospitals is not as simple as one might hope, so be a little wary of some published rankings.

References

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Answer to question this month: d) according to reference number 6, the estimated amount is $83,000