PSA

Patient Safety America Newsletter

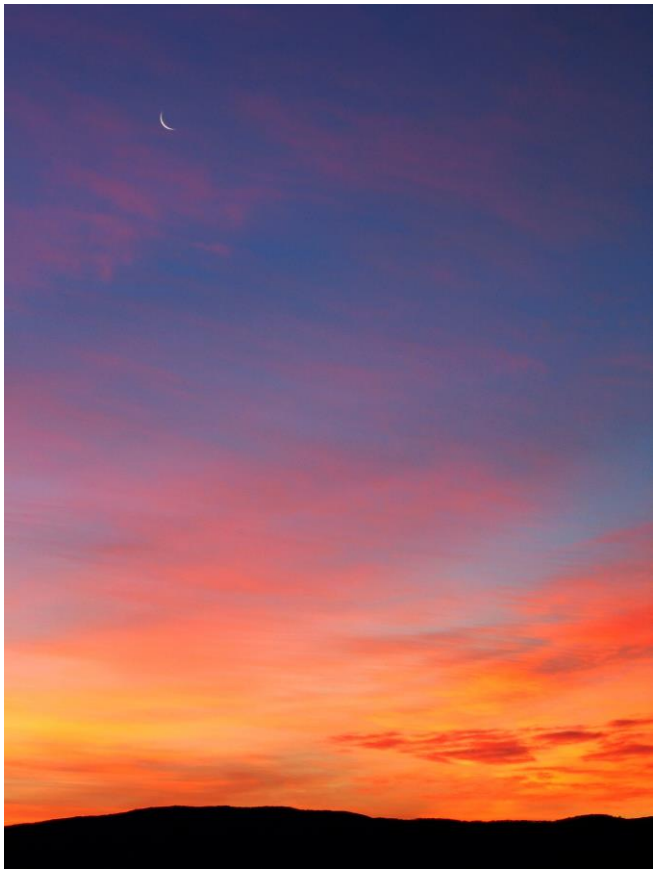
January 2015 http://PatientSafetyAmerica.com John T. James, Ph.D.

***Question**: The money per person spent on healthcare in developed countries and life expectancies in those countries are directly correlated.*

a) True b) False

Sunrise, Sunset, Swiftly Flow the Days

So goes the morose song with lyrics by Sheldon Harnick from *Fiddler on the Roof*. Two articles caught my eye this month, like the book ends of life. The first had to do with the difficulty of cajoling physicians to back off on their prescribing of antibiotics to hospitalized children.[1,2] The second had to do with a call to transform the way our medical industry provides end-of-life care.[3,4]



The first article calls for improved antibiotic stewardship, which means not prescribing a worthless antibiotic to children, keeping the duration of dosing of the proper antibiotic as short as possible, and not prescribing too many antibiotics at once. The author notes that three years ago only 16 of 42 free-standing children's hospitals were practicing antibiotic stewardship.[1] When infectious-disease specialists looked at the antibiotics prescribed to non-critical, pediatric hospital patients, they made recommendations for changes in 17% of the cases. The main recommendation was to stop the antibiotic in question. When the pediatrician refused to follow the recommendation of the infection specialists, there was a 3.5% readmission rate to the hospital within 30 days, whereas when the recommendations were followed, there were no readmissions within 30 days.

The lesson here is for those looking after the care of a hospitalized child. If the child is prescribed an antibiotic, determine the pediatrician's rationale for that prescription and ask to have a consult by an infectious disease specialist if the answer is not convincing to you.

Let's go on to the other bookend of life – the last days and weeks of earthly life – sunset, if you will. This is not exactly the best topic for discussion at a dinner party, but it is something we all must face, either as the caregiver of a dying person or as the one living out our last days. End-of-life care is called palliative care and focuses on keeping the patient pain free, reducing other adverse symptoms, and maintaining quality of life to the extent possible. It is not about prolonging life at the sacrifice of quality of life. Most people would prefer to die comfortably at home. Several major medical institutions, such as the Mayo Clinic are placing more emphasis on end-of-life discussions and palliative care.[3] A summary article in the *JAMA* lists the components of palliative care promulgated by the Institute of Medicine.[3,4]

One of the problems with end-of-life care centers on the fee-for-service model that continues to stain medical care in our country. I cite as an example of this phenomenon the four-fold difference in the rate of referrals of nursing home residents with advanced dementia to hospitals. Those with managed care were four-fold ***less*** likely to be referred than those cared for under a Medicare fee-for-service model.[5] Survival and comfort did not differ between the two groups. I summarized this article in the February 2014 newsletter.

A trusted colleague who recently helped managed the end-of-life care of a loved one employed an approach she had been given to consider. This was to not do anything that would have to be undone to near the end. For example, it is easier to not insert a feeding tube than to deliberately remove this near the end. Of course this all applies to those who are ***certainly*** near the end.

A few years ago relatives of mine were called to travel from Kansas to south Texas because an elderly family member was expected to die soon in a hospital there. When my family members arrived they discovered that the woman was indeed near death, but had had all her medications stopped by her doctors. She was highly bloated. They insisted on a restart of her medications, one of which was a diuretic. She recovered quickly and lived a good quality of life for several years after this. Her doctors had nearly killed her and her chance to enjoy several more years of quality life by a medical error of omission. Likewise a recent case out of California alleges that an 80-year old woman was not dead when her doctors sent her body to the morgue. There is clear evidence of her struggling to escape the body bag in which she had been placed (Frozen Alive).

Choose Wisely when Screening for Cancer

A viewpoint article by three experts in the *JAMA* hit on a common theme that forms the backdrop for overuse of cancer screening.[6] The writers point out what you should already know: your decision to be screened for cancer depends on your personal risk of that cancer and your life expectancy. So often these factors are ignored by the medical community. The authors cite an article showing that unhealthy 75 year olds are twice as likely to be screened for colon cancer as healthy 76 year old persons, even though the life expectancy of the former is much less than the latter. In what seems to me to be almost comical, another study is described in which almost half of physicians surveyed said they would screen a woman for breast cancer even though she has terminal lung cancer. The writers suggest that the US medical care system is failing patients in this regard – and wasting money and causing harm in the process.

If you planned to be screened for cancer of any type, make sure you know your personal risk of having that cancer and your life expectancy. Your life expectancy may be quite independent of your chronical age. Here is a life-expectancy calculator from the University of Pennsylvania: Life. Your risk is probably a good thing to discuss with your doctor based primarily on your genetic composition and family history of cancer.

While cancer screening is in your mind, you might ask how much money is spent on imaging as part of cancer care in a fee-for-service system vs. a managed-care system. To test for this difference a team of experts compared the amount spent on imaging in a Medicare fee-for-service system with the amount spent in the Veterans Administration (VA) managed-care system.[7] The population studied was older men with prostate, lung, or colorectal cancer. The annual cost per man of imaging in the VA group was $197, whereas in the Medicare group it was $379. The investigators also found substantial geographic variation in both systems.

I conclude from this that the temptation to overuse of imaging procedures in fee-for-service systems is simply more than the caregiver community can resist. Medicare needs to get a grip

on this problem because a lot of your tax dollars are being wasted on useless medical procedures, including imaging.

Disruptive Behavior

Over the holidays I spent several days with my three wonderful grandchildren (ages 1, 3, and 4 years). One of the keys to enjoying their company is to avoid situations where they can become disruptive. Typically, we either go to a noisy restaurant to eat or one that has a corner where we can avoid disruption of the clientele. Disruptive behavior can be expected from small children, but we assume that they outgrow this by the time they are adults. Unfortunately, some doctors have failed to outgrow their disruptive behavior.

It is estimated that about one in twenty five

doctors has shown disruptive behavior, being described as overt anger, physical threats, and an uncooperative attitude.[8] This sort of behavior impedes patient safety. For example, one study of nurses, doctors, and administrators found that two thirds of those surveyed reported that disruptive behavior was associated with adverse events. In another study of doctors, nearly three fourths reported that they had witnessed disruptive behavior in the past month.

What should be done about this problem? The article cites some strategies that I would call half-hearted - mushy stuff like hospitals declaring behavioral codes or accreditors declaring physician performance measures like "interpersonal skills."

What must be implemented is a 360-degree review system of hospital professionals. Under this system, each person that gives professional care in a hospital is anonymously evaluated by several subordinates, peers, and service leaders, as well as patients. The approach should be tiered. Tier 1, lasting 2 years, would be to give the results to the evaluated professional for self-correction. After that, tier 2 begins in which the results are given to hospital administrators and made accessible to the public in a general sense. For example, one hospital may have 1% highly disruptive professionals, whereas another might have 10% disruptive professionals. The third tier would be to specifically identify disruptive employees in a database accessible by the public. At this point I suspect that the disruptive behavior would be severely curtailed, either by behavioral changes by the individual or by dismissal from the hospital care team.

US Healthcare – OMG

A Stanford University economist posted an interesting viewpoint piece in the *JAMA*. His major point was to say that life expectancies and healthcare expenditures are in fact uncoupled.[9] He does this by comparing life expectancies and healthcare expenditures in developed countries of the Organization for Economic Cooperation and Development and in individual states of the U.S. He points out two startling observations. If our country spent as great a percentage of our gross domestic product on healthcare as the next higher-spending, developed country, we would spend a ***trillion*** fewer dollars each year. Furthermore, if folks in the U.S. lived as long as the average life expectancies in other developed democracies we would live an average of 2 years longer.

Can you think of the many useful ways our country could spend a trillion dollars? We could start with public education and infrastructure improvements. Personally, I'd like to see more spent on space exploration (now about 0.017 trillion dollars). Finally, we could use this to pay down the ridiculous national debt that we are passing on to our children and grandchildren.

Handoffs in Hospitals

A huge team of investigators asked how effective a restructured handoff plan for medical residents would be at reducing medical errors in nine hospitals that provide training in pediatrics.[10] Due to reduced work hours, resident handoffs are more critical than ever. It is well known that omission of critical information and mistaken information are often part of handoffs. The oral and written parts of handoffs were standardized and additional training was provided to residents. The

rate of medical errors decreased from 25 to 19 per 100 admissions and the rate of preventable adverse events decreased from 4.7 to 3.3 events per 100 admissions. Note that many medical errors do not result in a preventable adverse event (patient harm).

The message here is that even with improvements, harmful medical errors are common in pediatric services. As one who looks after the care of children while hospitalized, you must be vigilant in detecting and correcting any missed communications you discover.

Don Berwick on Reshaping US Healthcare

Don Berwick used to be head of the Centers for Medicare and Medicaid Services and recently ran for governor of Massachusetts. He wrote an editorial in the *JAMA* proposing a way to improve the care in this country.[11] He begins by pointing out how the universal insurance system in his state has resulted in "confiscation by health care of opportunities for growth and success of other sectors." This is happening in states across the nation. Doctor Berwick notes the gridlock in Washington, so he turns instead to local action for change. Can cooperation be generated at the local level and replace confiscation of money needed elsewhere? He notes that this will not be easy given the endemic nature of institutional self-interest. Berwick points to the potential sources for change: laborers who want to protect their families, businesses that want to remain competitive, citizenry that is better informed, and healthcare professionals who want more meaning and less hassle in their professional lives.

I am going to disagree with the good doctor, except on his point about the need for a better informed citizenry. Two points of information that all citizens need to know: harm from negligent and uninformed medical care that seriously harms a person is "medical battery" (or medical manslaughter if death ensues), and falsification or omission of information in medical records when harm has occurred constitutes tampering with evidence. All people must be informed of these facts so they can act when harmed. The U.S. Justice Department should handle such cases guided by a non-governmental National Patient Safety Board.

Additionally, I think informed citizens need to take to the streets and demand that the federal government do something about our broken healthcare system. As I understand it, the following steps are under the control of Medicare officials: It is not supposed to pay for procedures that are not necessary for the patient's care, yet it continues to do so. Step 1: Stop bogus payments! Step 2: develop an agenda to phase out fee-for-service medical care within 5 years and make it happen. Step 3: as a condition of participation, Medicare should require hospitals to perform 360-degree reviews of their doctors then transparently report the results.

References

1) Slomski A. Antibiotics for children: when less is more. JAMA 2104; 312:2079-2080. http://jama.jamanetwork.com/article.aspx?articleID=1938560
2) http://bit.ly/1rDWENr
3) Graham J. IOM report calls for transformation of end-of-life care. JAMA 2014; 312:1845-1847. http://jama.jamanetwork.com/article.aspx?articleid=1930814
4) http://bit.ly/1p1AGDQ
5) Goldfeld KS, Grabowski DC, Caudry DJ, Mitchell SL. Health insurance status and the care of nursing home residents with advanced dementia. JAMA Intern Med 2014; 173:2047-2053. http://archinte.jamanetwork.com/article.aspx?articleid=1740697
6) Saini SD, van Hees F, Vijan S. Smarter screening for cancer – possibilities and challenges of personalization. JAMA 2104; 312:2211-2212. http://jama.jamanetwork.com/article.aspx?articleid=1983689
7) McWilliams JM, Dalton JB, Landrum MB, et al. Geographic variation in cancer-related imaging: Veterans Affairs Health Care System versus Medicare. Ann Intern Med 2104; 161: 794-802. http://www.ncbi.nlm.nih.gov/pubmed/25437407
8) Sanchez LT. Disruptive behaviors among physicians. JAMA 2014: 312:2209-2210. http://jama.jamanetwork.com/article.aspx?articleid=1900087
9) Fuchs VR. Critiquing US health care. JAMA 2014; 312: 2095-2096. http://jama.jamanetwork.com/article.aspx?articleid=1918556
10) Starmer AJ, Spector ND, Srivastava R, et al. Changes in medical errors after implementation of a handoff program. N Engl J Med 2014: 371:1803-1812. http://www.nejm.org/doi/full/10.1056/NEJMsa1405556
11) Berwick D. Reshaping US health care – from competition and confiscation to cooperation and mobilization. JAMA 2014; 312: 2009-2010. http://jama.jamanetwork.com/article.aspx?articleid=1938542

Find past newsletters:
http://patientsafetyamerica.com/e-newsletter/

Answer to question this month: False (reference 9)