

Doctors Say Many Obstacles Block Paths to Patient Safety

By Bill Steiger

One doctor says his hospital is “reusing disposable instruments in the OR (operating room) to save a little money.”

Another acknowledges that radiologists order additional tests for a patient even if the diagnosis is confirmed. “It’s clearly a way of making additional revenue.”

And one physician says his hospital’s young chief operating officer once compared the hospital to a donut shop. The COO told the physician:

“We are like a donut shop. Our job is to sell donuts. If we don’t sell a lot of donuts we go out of business. Your job, as chief of emergency services, is to convince patients they need to be in the hospital and to convince doctors they have to admit patients. It is not your job to decide if the admission is good for patients.”

Those are just a few of the thousands of comments shared by physician leaders across the country who filled out the American College of Physician Executives’ 2007 Quality of Care Survey.

The survey was completed by 1,155 physicians in hospitals, group practices and other health care organizations. It explored a wide range of quality and patient safety issues, particularly the obstacles physicians encounter as they try to improve patient care.

Money was among the top four obstacles identified by the physicians:

1. Lack of resources and money
2. Patient compliance and awareness of healthy habits
3. Poor communication among physicians, nurses and paraprofessionals
4. A desire to maintain the status quo

About 20 percent of physicians in the survey said decisions about quality and patient safety frequently favor the organization rather than what’s best for the patients. About 34 percent said that happens sometimes, and

IN THIS ARTICLE...

A 2007 Quality of Care Survey conducted by the American College of Physician Executives reveals many frustrations for doctors trying to deliver safe, high-quality patient care.

another 37 percent said decisions favoring the organization over the patient are “seldom” but they do happen.

For example, two survey takers noted that doctors want patients to be discharged from hospitals before they undergo magnetic resonance imaging (MRI.) That’s because the reimbursement rates for outpatient MRIs are higher.

Among the hundreds of other cost-cutting moves that impact patient care that were pointed out by the survey participants included:

- “War readiness occasionally trumps patient care and quality in a military setting.”
- “All transitioning babies are admitted to an intensive care area rather than a well-baby holding area in order to be able to eliminate nursing positions.”
- “(We) discharge the patients prematurely because hospital will lose money.”
- “We really need to upgrade our defibrillators for safety reasons but due to finances this was nixed.”

And one physician recounted a meeting with the CEO:

“A case management program for the frail elderly was recently cancelled despite a proven track record of reducing hospital admissions and ED (emergency department) visits while saving the Medicare program 11% PMPM (per member per month) when compared to a similar control group.

“The CEO of the hospital came to me one day and asked: ‘Tell me again why we have a program that decreases my admissions and reduces the utilization of my ED?’



Doctors Lash Out at Joint Commission Rules

Among the many obstacles to patient safety that physicians cited in ACPE's 2007 Quality of Care survey one came up repeatedly: the regulations issued by The Joint Commission. Here's a look at some of the complaints lodged by doctors who participated in the survey:

- "JCAHO requirements that become implemented are sometimes at odds with the real needs of patients even though they are supposedly driven to ensure patient safety. They take the control away from the physician/nurse-patient relationship where it should be."
- "Medication reconciliation should help the patient but has really been done to meet JCAHO requirements—time-consuming, poorly done, doesn't currently aid the care of patients."
- "Locking up the drugs to satisfy JCAHO leaves us unable to respond in a timely manner to urgent/emergent issues with our pediatric patients in the OR. Being unable to treat laryngospasm immediately because the drugs are inaccessible occurred to me YESTERDAY in the PACU."
- "In a very busy operating room, with a central anesthesia workroom, the administration wants to keep the door locked (not closed, but locked) during the busy working hours, to appear to comply with JCAHO rules. There are in excess of 80 providers and 20 technicians using that workroom constantly during working hours. It is the area where critical equipment (defibrillators, IV pumps, cardiac monitors, etc) are stored, together with all the supplies. It is contrary to

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"To tell you the truth, I couldn't blame him. Despite our best efforts, we couldn't get the Medicare intermediary to see the wisdom of financially supporting the program and my CEO wasn't paid to do preventive care."

A related question in the survey asked:

Generally speaking, how are resource allocation decisions that affect health care quality and safety made in your organization? The answers appeared to back up some of the concerns aired by the physicians.

- About 43 percent said resource allocations were made with patient safety as the primary focus.
- But 33 percent said cost was the primary focus.
- And 14 percent said clinician efficiency was the primary focus.

ED emergency

Physicians in the survey indicated that one of the most pervasive problems affecting good care is patient flow, often involving huge backups in the emergency departments.

"The hospital is overcrowded, resulting in closure of the ED to new patients 30% of the time," one physician wrote. "Patients are kept in the ED holding beds for up to two days, waiting for beds in the hospital. More inpatient beds are available, but floors are kept closed because staffing them would cost too much."

"Our ERs are very overcrowded," another wrote. "We are currently expanding the hospital, but the regulatory requirements in (California) are horrendous and seem to fight expansion at every turn. As a result, patients are placed on gurneys, in chairs. We have tried to be innovative in providing triage and care. A few months ago, we had one patient that was seen, triaged, (had) labs done and treated without every leaving the bench outside the ER."

Below is a list of some of the most common obstacles to providing high-quality health care and patient safety initiatives. Please rate each one as it relates to your health care organization.

	Not an obstacle	Sometimes an obstacle	A major obstacle
Lack of resources/money	10% (116)	55% (626)	35% (403)
Federal government policies	20% (234)	62% (703)	18% (205)
Insurance companies' practices	20% (229)	50% (568)	30% (345)
Patient compliance and awareness of healthy habits	7% (75)	59% (678)	34% (391)
Physician resistance to use evidence-based care	12% (137)	61% (690)	27% (313)
Administrative culture that doesn't support quality/safety initiatives	41% (473)	41% (469)	17% (199)
Clinician communication and culture (interaction of physicians, nurses, and paraprofessionals)	11% (123)	56% (638)	33% (383)
Fear of reporting quality and safety problems	22% (253)	49% (565)	28% (326)
A desire to maintain the status quo	12% (141)	52% (601)	35% (403)
Total Respondents (skipped this question)			1147 8

“The hospital where my group practices is extremely overcrowded leading to significant patient flow issues and increased risk for medical errors,” another survey participant explained. “It is a ‘disaster waiting to happen.’ The hospital administration and board are not committed to making sufficient improvements. Consequently, my medical group is assisting a competing hospital in an expansion project and will move our practice to the new hospital.”

Questionable care

Along with patient flow, other serious inefficiencies that affect care were cited by the physicians who took the survey such as:

- Overuse and underuse of care
- Unexplained variances in care
- Medical errors, including problems with nursing or pharmacy

Here’s a look at a few of the many comments:

“We have variance in our ER pertaining to the frequency of CT scans ordered, depending on the physician. It is sometimes used in place of an initial appropriate physical exam, and results in increased cost due to nighttime teleradiology services and call-in of radiology technicians; patients complain about some physicians spending little time in the room with them. We are

the best interest and safety of the patients to lock that room during busy hours. This workroom is within a secure area of the hospital (operating room suite)."

Pat Adamski, director of the The Joint Commission's standards interpretation group, said the Commission is required to meet the Centers for Medicare and Medicaid Services' medication security rules.

However, the rules were actually relaxed earlier this year. "They've really taken a more common sense approach to that," Adamski said. For example, while all controlled substances naturally need to be locked up, other drugs used in busy operating rooms and other clinical areas don't necessarily have to be under lock and key.

"A staffed OR suite is considered secure," she explained. However, during off-hours or weekends, the drugs do need to be locked up.

"What I see in these comments (of the survey participants) is that's the way it used to be. But as of the end of January, things changed," Adamski said.

As for the other comments about the Commission standing in the way of good patient care, Adamski said it's often the hospitals themselves that figure out how to interpret and implement the guidelines. Some hospitals may employ tougher rules than are necessary and simply blame it on The Joint Commission.

Adamski urged physician executives to sign up for a list serve on the Commission's Web site where they can view comments from the field that are taken very seriously by the Commission. "We look at every single comment that comes in. We want to make sure we're not tying people's hands when it comes to patient safety. ...We always listen to feedback and make adjustments when we need to."

She said there are also about 17 pages of frequently asked questions on the site concerning medication reconciliation that might help hospitals fulfill that responsibility more easily.

—By Bill Steiger

presenting comparative data to the physicians and have distributed a list of appropriate indications. A radiologist must be consulted if the order does not meet the requirements of the list."

"Pharmacy is extremely tardy delivering medications to nursing units, markedly delaying appropriate care," another wrote. "Pharmacy makes independent and arbitrary judgments about drugs and dosages that have no bearing on clinical care, do not deliver the medications to

nursing units and do not call the physician to voice their concerns. Only when a physician inquires as to when med was administered is it discovered that med was not sent from pharmacy. Writing up pharmacy on risk management forms has not corrected the unlicensed practice of medicine by hospital pharmacists."

"Many times 'overuse' of care (occurs) as everyone tries to cover themselves against medical malpractice suits. This sometimes leads to extra procedures that may put the

patient at risk (i.e., sedation, general anesthesia, IVs, etc.) increasing the potential for errors. We try to 'fix it' by using evidence-based practices but unfortunately no one wants to be the one feeding the trial lawyers."

"Our community has the highest rate of instrumented lumbar spinal fusion, roughly 600% above the national average according to the *Dartmouth Atlas*. Expert guidelines on the use of such procedures are generally not observed. As a result, inappropriate and unnecessary fusions are performed and far too many patients are left unimproved or worse. The costs for a fusion run as much as \$50,000 to \$60,000 or more, and without evidence that it offers any advantage over conservative care, it is unconscionable that this inappropriate utilization is tolerated. Yet, the surgeons who perform these operations are among the most powerful in the community because of the revenue they generate and no one is able to 'take them on' without fear of reprisal."

Profit over patient care?

Other concerns raised by the physicians in the survey were situations where low quality is tolerated for physicians or departments that generate high amounts of revenue.

Sixty-one percent of the respondents said that isn't a problem in their organizations, but 39 percent said it is.

"Physicians who have a high volume and low quality scores are counseled but not fired. Physicians with low volume and low quality are fired," one survey respondent complained.

Another targeted, "high-volume surgeons who couldn't pick their patients out of a line up even if you put name tags and flashing lights on them. Medical care is something for the rest of the peons to deal with once the sutures are in place."

Several specialties were singled out. Here's what some survey participants had to say:

Cardiology:

“A cardiologist was called by the ED for an acute MI (myocardial infarction) to go to the cath lab. He delayed several hours (it was in the middle of the night when he was called) and finally did the cath the next morning with a stent. The case went to the quality committee, but there were never any real repercussions from it.”

“An interventional cardiologist with questionable skills (is) being allowed to continue with endovascular procedures because he's part of the dominant cardiology group.”

“One of our highest volume cardiac catheterization physicians routinely exercises questionable judgment. All in administration acknowledge this but do not ‘rock the boat.’”

Orthopedics:

“Orthopedic surgeons are tolerated in their unprofessional behavior and erratic delivery of care, as long as they keep booking their spines and total joints.”

“An orthopedist who is terribly out of date and refuses ED call, but is intimidating and generates big bucks for the hospital.”

“Orthopedic surgeon signed off on a surgical procedure BEFORE he had done it. No significant reprimand.”

General surgery:

“Surgeons have longest wait times in their clinics, highest rate of not coming to clinics, poorer than expected performance on state CABG report card, yet nothing is done to correct (the) situation.”

“One busy surgeon has the WORST POSSIBLE patient assessment and screening. His H&Ps (patient histories and physi-

cal examinations) are laughable, and bear NO resemblance to the patient's real conditions. But the hospital WILL NOT deal with it, even when pounds of documentation have been supplied to the safety and quality committee.”

Support available

Despite all the rants, the physicians in the survey did report that doctors generally are in favor of improving patient safety and quality.

Nearly 86 percent of the survey respondents said physicians are

Have you ever struggled with finding an appropriate balance between what you believe is best for the patient(s) and what's best for your health care organization when it comes to implementing quality/safety initiatives?

	Response %	Response Total
Yes	59.1%	676
No	37.7%	431
Not applicable	3.1%	36

Total Respondents 1143
(skipped this question) 12

How frequently are decisions about quality/safety initiatives made at your health care organization that favor the organization rather than what you believe is best for the patient(s)?

	Response %	Response Total
Always	1.8%	12
Frequently	19.7%	132
Sometimes	33.7%	226
Seldom, but it happens	37.1%	249
Never	7.7%	52

Total Respondents 671
(skipped this question) 484

In your health care organization, are there situations where low or poor quality is tolerated for physicians or departments that generate high amounts of revenue?

	Response %	Response Total
Yes	39%	436
No	61%	682

Total Respondents 1118
(skipped this question) 37

Generally speaking, how supportive are the physicians in your organization of quality and patient safety improvement projects?

	Response %	Response Total
Very supportive	34.1%	379
Somewhat supportive	51.9%	576
Slightly supportive	12.6%	140
Not supportive	1.4%	15

Total Respondents 1110
(skipped this question) 45

Does your organization have physician financial incentives (pay for performance or other bonuses) that are aligned with improving the quality of care?

	Response %	Response Total
Yes	23.9%	264
No	76.1%	841

Total Respondents 1105
(skipped this question) 50

either “very supportive” or at least “somewhat supportive” of efforts to boost safety and quality. Only about 13 percent said doctors were “slightly supportive.”

In an open-ended comment field at the end of the survey, the physicians posted many concerns about the obstacles they face to make health care better and safer.

“Quality/safety initiatives are discussed constantly, and we are all expected to increase the amount of work we do to meet those objectives. No additional human resources are allocated, however—in fact, the administrative workforce is being reduced through attrition,” one doctor wrote.

Another said: “We have effective and efficient quality and safety measures within our own hospital physician network and hospital-based physicians, with very good buy-in and participation from the physicians. Our problem is with the independent medical staff who seem to think they know everything and the hospital exists to improve their efficiency, and further, that quality is defined by their getting whatever they want and not by any measurements. They fight us just about every step of the way.”

Some blamed leadership.

“(Our) board of directors is publicly elected (i.e., popularity contest) and essentially clueless about running a health care organization—all have their own agendas which is not always putting quality first in spite of their public comments. Most have a serious conflict of interest.”

The survey did find, however, that physicians sit on the boards of nearly 85 percent of the survey respondents’ organizations.

Other physicians reported making strides in the right direction.

“In my areas the primary obstacle was getting people—physicians, nurses, other staff—to believe they could make the change. And, to believe that they could provide

the best care possible. Once they believed that, and that there was room to improve, there was no stopping them.”

But a large number focused squarely on finances.

“(The) greatest obstacle is not having the decision making financial relationship between the patient and the physician (not the insurance company). This, along with caps on non-economic mal-practice judgments, would allow market forces to come into play, and would significantly reduce the overall cost of health care, with a likely increase in overall quality.”

Another said, “Most health systems don’t understand the key concepts of safety, and how to build a culture of safety and quality mindfulness—preferring to focus on cost, and image.”

Generally speaking, how are resource allocation decisions that affect health care quality and safety made in your organization?

	Response %	Response Total
With patient safety as the primary focus	42.9%	461
With clinician efficiency as the primary focus	14.2%	153
With cost as the primary focus	32.7%	352
Other (please specify)	10.1%	109
Total Respondents (skipped this question)		075 80

Below is a short list of problems that can contribute to waste and inefficiency in a health care organization and impact the ability to deliver safe, high-quality care. Please rate the inefficiencies as they relate to the quality of care at your organization.

	Not a problem	Sometimes a problem	A major problem
Medical errors, including nursing and pharmacy	11% (121)	76% (831)	13% (140)
Overuse or underuse of care	9% (103)	58% (637)	32% (349)
Complications from procedures (such as infections)	25% (269)	68% (741)	7% (77)
Unexplained variance in care	11% (123)	61% (664)	28% (301)
Patient flow problems	8% (89)	49% (537)	42% (460)
Total Respondents (skipped this question)			1093 62

In which sector of health care are you currently employed?

	Response %	Response Total
Hospital	43.5%	458
Group practice	26.1%	275
Insurance/managed care	7.4%	78
Government	5.8%	61
Industry	1.5%	16
Academia	7.5%	79
Other (please specify)	8.1%	85

Total Respondents 1052
(skipped this question) 102

Please choose the category below that best describes your title or position.

	Response %	Response Total
CEO, Administrator, President, COO, Commander, Dean or similar	8.7%	92
VPMA, CMO, CIO, CQO, Chief of Staff, Vice Commander, Assoc Dean, or similar	30.9%	326
Medical Director of a Hospital or Group Practice	17.1%	180
Clinical Department Chair, Chief of Service, Medical Director of Clinical Department, Residency Director, Professor of Medicine or similar	25.2%	266
All Other Positions including Practicing Physician, Consultant and Resident/Fellow	18%	190

Total Respondents 1054
(skipped this question) 101

“Money, money, money,” one chanted. “(We) need more resources in staffing beds (nurses), need more beds—inadequate number of ICU and telemetry beds vis-a-vis ED volume and admission rate. Hospitalist program needs more MDs.”

And several answered the final, open-ended question about obstacles to quality and patient safety by simply typing one character repeatedly.—\$\$\$
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Bill Steiger is editor of *The Physician Executive*.

Details of the 2007 ACPE Quality of Care Survey

The survey was sent to 7,152 members of the American College of Physician Executives on Feb. 1, 2007.

A total of 1,155 doctors completed the survey—16%. The survey was closed on Feb. 16, 2007.

Members of the college include physicians and physician administrators working at hospitals, small and large group practices and a variety of other health care organizations.

All ACPE members are physicians.

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