Online Hospital Ratings to Include More Data

BY DAMIAN McNAMARA

MIAMI BEACH — More information on risk-adjusted mortality, a greater focus on patient satisfaction, and a better user experience are coming to online hospital quality comparison sites, according to a physician specializing in quality improvement.

Current comparison systems are imperfect, Dr. Peter Lindenauer said. "Even relatively strong proponents of public reporting [think] that the information we have available today is insufficient to make the decisions, and many continue to rely on word of mouth recommendations from doctors who are familiar with the hospitals themselves."

Enhancements are planned for Leapfroggroup.org, whynotthebest.org, and the Department of Health and Human Services' site at HospitalCompare.hhs.gov. Public awareness of these hospital quality ratings and comparison data is growing but still not widespread. "Only about 6% of public surveyed were aware of this [HHS] Web site," Dr. Lindenauer said at a meeting on perioperative medicine sponsored by the University of Miami.

"Once we have risk-adjusted mortality, process-based measures, and patient satisfaction ratings, it will get harder and harder to ignore the ratings," said Dr. Lindenauer, director of the Center for Quality of Care Research at Baystate Medical Center, Springfield, Mass.

Many quality comparisons are based on hospital mortality, but "there is limited power to discriminate good and bad hospitals on the basis of mortality," Dr. Lindenauer said. One study, for example, found that hospital caseloads of most surgical procedures—with the exception of coronary artery bypass grafting—were not high enough to show a statistically significant difference in surgical mortality between institutions (JAMA 2004;292:847-51).

Increasingly, hospitals are promoting their performance ratings on their Web sites.

DR. LINDENAUER

Risk adjustment of outcomes would provide more accurate comparisons of mortality and other outcomes, but "it's hard to do and it's expensive," said Dr. Lindenauer, who is also on the medicine faculty at Tufts University, Boston.

Often, patients are not aware of the value of risk-adjusted outcomes data or make choices based on other factors. For example, when former President Bill Clinton had quadruple bypass surgery in September 2004, he chose New York–Presbyterian Hospital/Columbia University Medical Center, even though the institution's risk-adjusted CABG mortality was about two times the state average. "Like other patients, he did not choose his hospital based on publicly reported data. It's likely that his decision was influenced by the usual referral patterns from the local hospital at which he was first admitted," Dr. Lindenauer said.

Debate continues over the relative importance for hospital performance reviews of outcome measures, structural measures (such as the availability of intensivists or computerized physician order entry), or processes (such as use of beta blockers for acute MI), Dr. Lindenauer said. The Pennsylvania Health Care Cost Containment Council, for example, focuses on outcomes and reports all hospital-acquired infections in the state. In contrast, the Leapfrog hospital ratings are structure based and examine such factors as intensive care unit staff, nursing staff, and use of electronic medical records. Whynotthebest.org is process oriented—measuring, for example, the use of strategies to prevent deep vein thrombosis.

Dr. Amir Jaffer, chief of the division of hospital medicine at the University of Miami, asked Dr. Lindenauer if he would recommend one Web site as best for consumers. "At this point in time, I don't think there is any one site," Dr. Lindenauer replied. "The HospitalCompare site is a key one, but not the most user friendly. The California Hospital Outcomes project [CalHospitalCompare.org] is good, and Whynotthebest is in beta right now and has kinks that need to be worked out."

The effects of publicly reported quality ratings on a hospital's reputation can go both ways. "Hospitals want to avoid embarrassment, but it's becoming increasingly common for hospitals to promote their performance ratings on their Web sites," Dr. Lindenauer said, citing Aventura (Fla.) Hospital and Medical Center as an example. On its Web site (www.aventurahospital.com), it touts its HealthGrades 2008 Distinguished Hospital Award for Clinical Excellence, received for being ranked in the top 5% of U.S. hospitals. ■

Awareness of Top Causes of Lawsuits Can Reduce Risk

BY DAMIAN McNAMARA

MIAMI BEACH — Hospitalists are most likely to be targeted by malpractice claims that involve alleged informed consent issues, standard of care, or errors resulting from poor communication.

Physicians still win more than half of malpractice cases, Dr. Franklin A. Michota Jr. said at a meeting on perioperative medicine sponsored by the University of Miami.

'Sometimes it doesn't matter if you do everything right. If you don't talk to the patient, you are going to get sued.'

DR. MICHOTA

Lawsuits are inevitable, he said. "I am estimating that 30%-40% of you in the audience have been sued." In general, surgeons are sued about once every 4 years, anesthesiologists once every 5 years, and internists once every 7-10 years. Hospitalists, as part of the perioperative team, are sued at about the same frequency as surgeons, said Dr. Michota, director of academic affairs for the department of hospital medicine at the Cleveland Clinic.

Poor communication is the leading reason physicians get sued, Dr. Michota said. "Sometimes it doesn't matter if you do everything right. If you don't talk to the patient, you are going to get sued."

Hospitalists can reduce their risk by paying attention to the top reasons for lawsuits, as illustrated by three actual malpractice cases presented by Dr. Michota and Matt Donnelly, chief counsel at the Cleveland Clinic.

Informed consent was the key issue in the case of a 65-year-old man referred for preoperative stress testing prior to total knee arthroplasty. He had a history of coronary artery disease and had marked limitation of activity as assessed by the Duke Activity Status Index; he also had chronic obstructive pulmonary disease, hypertension, and prior abdominal aortic aneurysm repair. Dobutamine stress echocardiography was performed with a target heart rate of 132 bpm. Sporadic premature ventricular contractions occurred, the man complained of shortness of breath and chest pain, and the test was stopped. He went into ventral tachycardia, then ventral fibrillation, and died despite resuscitative efforts.

Mr. Donnelly noted that the manner in which informed consent was obtained was central to this case. Was it obtained by the referring physician a few weeks before the stress test, or by the personnel who performed it? Was death as a potential outcome discussed with the patient or family as part of the informed consent process? Also, was there appropriate monitoring during the test?

"I've worked in perioperative care for 5 or 6 years now," Dr. Michota said. "I don't ever remember a time when I referred someone to a stress test where I told them they could die. I do now."

A lawsuit can be filed even if the patient signed a consent form in the stress testing laboratory, Mr. Donnelly said. A plaintiff's attorney might question whether the patient understood the risks, for example.

Standard of care issues are illustrated by a case involving a 75-year-old man with rectal cancer. He had a remote cardiac history but presented for surgery with good functional capacity on the Duke Activity Status Index and no symptoms. Surgery was uneventful, but he developed hypotension in the postanesthesia care unit. He improved the next morning. Bleeding occurred on postoperative day 2 and he was returned to the operating room, where he experienced cardiac arrest. He was revived but died 2 weeks later. An autopsy showed that myocardial infarction was the cause of death.

"The complaint was he did not have a proper cardiac workup," Dr. Michota said. Mr. Donnelly commented that the patient's cardiac condition was well controlled and "was way in the past." One of the main issues in the case was the question of whether an ECG should have been performed, Mr. Donnelly said. "You have to remind the jury that they have to think about what the physician was facing at the time, not retrospectively."

Hospitalists could be involved in such a case if they do a preoperative evaluation and do not order an ECG, even though it is not recommended in this scenario by the American College of Cardiology or American Heart Association, Dr. Michota said.

In response to a meeting attendee's question about what defines standard of care, Dr. Michota replied, "Often it gets down to a battle of the experts. If you work at a community hospital that orders stress testing for everyone and that seems like standard of care, a plaintiff attorney can still argue it was risky and never should have been ordered. Or you work at an institution that never orders stress testing, and the attorney will ask why you did not order it when it is available."

A third case shows the importance of documentation and communication. A 67-year-old man was seen for a consultation after developing shortness of breath following a laminectomy. He was started on full-dose low-molecular-weight heparin (LMWH), his symptoms resolved, and his workup was negative. The consultants signed off without stopping the LMWH. Discharged to a rehabilitation unit, the man did well until postoperative day 7, when he developed urinary retention and could not move his legs. The LMWH was stopped, and he underwent emergency surgery to evacuate a spinal hematoma. He never fully recovered neurologic function.

"This case was interesting because once the docs involved realized what happened, they got nervous and started finger-pointing," Dr. Michota said. The surgeons thought someone else was going to stop the LMWH. "Interestingly, the hospitalist in the case made a notation in the chart after the neurological injury occurred, but dated the entry as before the fact. Doctoring the medical record never plays well to the jury—it is a clear sign of guilt!" ■