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LETTERS FROM MAINE

Cookbook Medicine

Unless you've handed over the care of all of your sick patients to the hospitalists, you will have noticed cookbook medicine creeping into the care of your hospitalized patients. It comes clothed in several transparent disguises: "CareMaps," "standardized orders," and "algorithms" are the euphemisms for "recipe," the term with which we here in Brunswick are most familiar.

Now, when I admit a patient to the hospital with the diagnosis of bronchiolitis or a baby has the misfortune of being born a bit on the heavy side, a printer somewhere at the nurses' station spits out a set of legible and detailed orders that will determine that child's care for his or her hospital stay. So long as I manage to get a history and physical into the chart and sign the orders, no one will bother me.

I'm not sure exactly where the trend began or who was responsible for getting this ball of red tape rolling. Most of the push for standardized orders seems to be coming from the nursing service. However, I wonder if the risk-management folks also might have a hand in the process. I vaguely remember sitting through several tedious meetings where the standard orders were discussed, but like most documents created by committee, these orders ended up being inclusive rather than thoughtful. Few of the items would successfully pass an evidence-based test of validity.

While I have never claimed that inpatient pediatrics is fun, standardized orders make the process less intellectually stimulating and more impersonal. Whenever I sign on the bottom line, I feel as though I am admitting that I haven't been paying attention during my CME exercises and that I'm too old to be trusted making clinical decisions about sick patients. It's safe to say that since their introduction I have never been a big fan of standardized orders.

However, one of my partners recently gave me an article from the Dec. 10, 2007, issue of the New Yorker magazine by Dr. Atul Gawande, a surgeon/author. (If you haven't read any of his writings, I urge you to start with his first book, "Complications.") The article is titled "The Checklist" and describes how by developing a simple checklist for central line placement, Dr. Peter Pronovost, a Johns Hopkins University critical specialist, was able to prevent eight deaths from line infections and save $2 million in a single hospital in a single year.

The article goes on to describe how Dr. Pronovost has developed other evidence-based checklists, including one for the care of ventilated patients. The cost savings and life-sparing statistics are truly remarkable and have been effective in many other hospitals. Even the country of Spain has bought into the program and plans to implement it nationwide.

The ingredients in Dr. Pronovost's recipes are rather mundane and include such simple tasks as making sure the head of the bed is raised to 30 degrees for ventilator patients, that all ventilated patients receive antacids, and that any patient having a line placed has sterile drapes. Critical care units have such complex patients that rigorous attention to even the most basic factors is necessary to achieve a significantly improved outcome. As I read the article, I was reminded of the story of how a girl in Wisconsin was rescued from rabies by a combination of heavy sedation and scrupulous attention to life support.

I'm not sure how Dr. Pronovost's checklists for critical care units translate to my unsatisfying experience with the standard orders. I guess that for me, the big take-home message would be that checklists or recipes must be clearly evidence based, not just cobbled together by those of us at the grassroots. The results aren't going to be dramatic because I'm not dealing with critically ill patients, but after reading Dr. Gawande's article, I'm ready to try a few new recipes from a well-documented cookbook. ■

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