Under My Skin

Too Little Vigilance

We all have hypervigilant patients who spend too much time staring at their bodies and calling us about minor variants of normal they ought to ignore. Then there are their opposite numbers, those with what you might call hypovigilance. This term applies not just to patients but to the people around them, both in and out of the medical profession—the ones who should be saying, "Hey, take care of that!" but don't.

BY ALAN ROCKOFF, M.D.

My parade example is the middle-aged cardiologist who came in years ago with his wife. He took off his shirt, and there, in the middle of his back, was a big melanoma. How long had the spot been there? Oh, about 3 years.

There's no problem explaining why he didn't come in sooner: It was on his back, and he's a male physician. But what about his primary doctor? (OK, maybe he does not have one.) And how about his wife? What was she thinking?

There might have been a mole there to start with, causing both wife and husband to incorporate the spot into their concept of his body image ("It's always been back there") in much the same way as people with birthmarks that others find ugly often don't have them removed because they "belong."

That explanation would not, however, work for two recent acne patients. One was a handsome 19-year-old with a 9-year history of major, scarring acne. Previous treatment? Proactiv. (Proactiv has to be the most brilliantly promoted product on the planet. How many acne patients do you see who have not used or asked about it?)

As he was saying, "You have to understand, doc. I'm a performer. I sing, I dance, I act. My face is important to me," I was thinking, "How the devil did he go 9 years without being treated or referred for this?"

Next was a 22-year-old college student, also with severe, cystic acne. She had been treated with long courses of antibiotics without sustained benefit. I broached the possibility of isotretinoin, which she thought was a fine idea because she'd researched it and several of her friends had taken it with success.

In other words, she had none of the usual fears and objections people have about this drug (depression and so on). Nobody, including the doctors who had taken care of her for several years, had ever talked to her about it. She is intelligent and acculturated, but nobody ever brought it up, and she hadn't pushed. How could this happen?

Then there was a 7-year-old girl who also came in last week with several bald scalp patches of boggy, oozing skin. This had been going on for a year. Treatment? Ketoconazole shampoo. "I think it got worse because her dad poked at it," said her mom.

Now, I haven't seen a kerion in ages, so it's not surprising that her pediatrician didn't recognize it. What I marvel at is this: Where the dickens is everybody? Why was her primary doctor willing to let this go? Where was her school nurse? Heaven knows school nurses send kids home for a lot less than this. And why has her mother not been raising an unholy ruckus to find out what the deal is with these icky bald spots instead of just blaming the dad?

I don't get it. But I see it all the time, as I'm sure you do. There might be many explanations, but the plausible ones often don't work. None of these cases involves people who lack insurance, who don't speak English, or who have cultural barriers that cause them to view Western medicine with hostility and suspicion.

We all can come up with many other examples of hypovigilance: The man who promises to come back to have an atypical mole re-excised and doesn't. The woman who's had half a dozen basal cells and agrees she should be seen every year and then returns a decade later only because she has a rash. And so on.

Many such people are, of course, beyond our control. Some will hopefully be corralled when barriers to care like unavailable health insurance are finally eliminated.

For the others, we'll just have to send a posse to go out and get 'em.

We can call them hypovigilantes. ■

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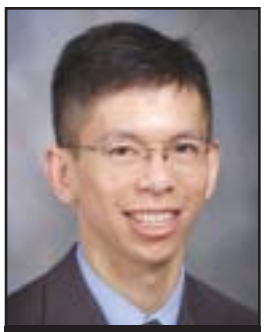
Guest Editorial

Making Quality Improvement a Priority

Health care errors have received a great deal of press lately, which is no surprise given that 784,000 deaths per year are attributed to medical injuries. It follows that quality assurance in health care is a hot topic these days as well, and that's a good thing, but change needs to be about more than quality assurance—it needs to be about quality improvement.

An inspection of quality issues in health care reveals a number of common themes associated with medical errors. For example, in many cases it is not a single error but a convergence of multiple errors that occurs. Inconsistent processes, a lack of process metrics, tremendous variations in practice, and tolerance of mediocrity also emerge as common themes in the setting of medical error.



BY TRI H. NGUYEN, M.D.

Quality improvement, therefore, is the science of process management and strives to promote reduction in practice variations, adherence to evidence-based guidelines, optimization of patient safety, enhanced quality of care, practice efficiency, and reduction of health care costs.

The quality improvement process begins with the Plan-Do-Check-Act cycle. Plan: Begin by identifying a priority process requiring change. Ask yourself: "What are we trying to accomplish, improve, or change?" Do: Establish baseline metrics of the process to be measured, which includes distinguishing between normal variations and important trends. Ask yourself: "How will we know that a change is an improvement?" Check: Summarize data and develop interventions. Ask yourself: "What changes can we make that will result in improvement?" Act: Introduce the interventions, and reassess metrics to measure improvements.

A few "golden rules" of quality improvement should be kept in mind:

- ▶ Quality improvement requires leadership and ownership by everyone involved.
- ▶ Quality improvement is not about name, blame, and shame, but about working together to achieve a common goal of improving health care quality.
- ▶ Quality improvement is transparent.
- ▶ Quality improvement is continuous.

A good example of a successful quality improvement program at M.D. Anderson Cancer Center, Houston, was an initiative to reduce Mohs surgery duration and the number of late surgical cases (beyond 5 p.m.). This was a priority process that directly affected health care quality. Longer-than-necessary surgery increases complications and patient fatigue, exhausts staff, and reduces revenue.

A Mohs surgical flowchart was constructed to identify breakdowns in the process. Baseline metrics were established, including the number of patients discharged after 5 p.m. in the previous 4 months, time in and time out of every surgical patient on the days patients were discharged late, surgical schedules on the days of the delayed cases, and a host of other related factors. Our baseline metrics demonstrated that nearly 13% of Mohs cases extended beyond 5 p.m.

Factors affecting late cases included tumor complexity, scheduling of complex cases, and patient education (informed consent, wound care, and so on). Interventions introduced included staggered scheduling with more complex cases scheduled later rather than earlier to allow simpler cases to be completed and discharged in a timely manner and to permit staff availability for multiple-stage surgeries, and an informed consent and wound care video to facilitate patient education.

The improvements were dramatic, with "late" cases dropping from 13% to 5%. In addition to improving patient satisfaction, the program improved team morale and participation in the quality improvement process, promoted development of a culture of transparency in assessing process failure rather than individual failure, and emphasized continuous improvement and staff empowerment to effect change.

This quality improvement training is so pivotal that I now require all procedural dermatology fellows to complete a quality improvement program as part of their training. Our current fellow is on her third quality improvement project. Her efforts have resulted in elimination of voice mail (a friendly human voice answers every patient phone call), improvement of chart documentation for patient calls from 0% to 90%, and a 50% reduction in patient call volume.

To err is human. Acceptance of this fact and a continuous commitment to develop error-reduction processes is the essence of quality improvement. Embracing this passion early and fully, as evidenced by our fellow's successes, will create synonyms of "quality" and "health care." Imagine what would happen if each fellow and resident were required to complete a quality improvement project before graduation—and if all of us took it upon ourselves to make quality improvement a priority. ■

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