Do Malpractice Concerns Drive Aggressive Care?

BY ALICIA AULT

FROM ARCHIVES OF INTERNAL MEDICINE

VITALS

Major Finding: Almost half of primary care physicians responding to a randomized survey said that they practice too aggressively; 76% said the overtreatment stems from malpractice fears.

Data Source: A survey of 627 primary care physicians randomly sampled from the AMA Physician Masterfile; 70% of physicians responded.

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Forty-two percent of physicians admit that patients in their practices receive too much treatment, which was described as "aggressive" care, according to a survey of general internists and family doctors. Fifty-two percent said that they thought the amount of care they provided was just right, and 6% said their patients received too little care.

When asked about their own practice style, 28% of respondents said they were too aggressive, ordering more tests and referrals than necessary. Just under 20% said they were practicing more conservatively than their ideal (Arch. Intern. Med. 2011;171:1582-5).

The doctors were also asked to describe practice styles among other health care providers and reported that they believed they saw too much testing and ordering of referrals by nurse practitioners, physician assistants, and specialists.

Twenty-nine percent said other primary care physicians were practicing too aggressively, while 61% said they believed that specialists are too aggressive in their practice and 47% said mid-level providers overtreat patients.

Malpractice concerns were cited by 76% of the survey respondents as a reason for their more aggressive practice style. Eighty-three percent of the physicians said that they feared being sued if they did not order an indicated test.

About half of those surveyed said that clinical performance measures led to more care, and 40% said that not having enough time with patients translated into a more aggressive practice. Instead of thinking through an issue, they order tests or make referrals.

Few physicians (3%) said that they believed financial considerations influenced how they personally practiced medicine. But 39% said they thought other primary care doctors would order fewer tests if there was no incentive. Sixty-two percent said that specialists would likely perform fewer procedures if they did not generate extra revenue.

The survey authors, led by Dr. Brenda E. Sirovich of the VA Outcomes Group, White River Junction, Vt., said that while many have debated just how much the fear of malpractice leads to more aggressive care, "based on our findings, we believe it is not a small effect."

"Our work shows that primary care physicians recognize the excesses of our health care system, can point clearly to some of the causes, and may be open to changing their own practices to address them," according to Dr. Sirovich and her associates.

The authors mailed a nine-page survey to primary care physicians, asking them to describe how they and their colleagues practiced medicine. A total of 627 physicians were randomly sampled from the American Medical Association's Physician Masterfile; 70% responded.

Most survey respondents were male, board certified, and reported a median of 24 years in practice.

Surveyed physicians were provided with an honorarium of $20-$100 for their participation. ■

VIEW ON THE NEWS

Defensive Medicine Is a Dead-End

"Implicit in these findings is a kind of trained helplessness – it seems that physicians know they are practicing aggressively but feel they have no recourse," Dr. Calvin Chou wrote in an invited commentary.

Dr. Chou suggests that defensive medicine is a dead-end; it is not a sustainable practice and there is no evidence that it actually prevents malpractice suits.

Instead, studies have shown that physicians sued the least are the ones who connect more with patients by actively listening and including them in their own care.

"Patients tend to define quality of care in terms of the quality of communication with members of their health care team," Dr. Chou wrote.

DR. CHOU *is a professor of medicine at the University of California, San Francisco. These comments were adapted from a commentary accompanying the report (Arch. Intl. Med. 2011;171:1585-6). He reported no relevant financial conflicts of interest.*

Joint Commission Drops Some Stellar Hospitals

BY ALICIA AULT

The Joint Commission issued a list of what it is designating as the top-performing hospitals in America, and the facilities that are not listed might be somewhat surprising.

Missing from the list of the "best of the best," a new designation this year, are Johns Hopkins, Duke, the Cleveland Clinic, the Mayo Clinic, M.D. Anderson, and even the Geisinger Health System, which has been hailed as a quality pioneer.

Out of the 3,000 hospitals for which the Joint Commission has been collecting performance data on for the last decade, 405 met the top performance criteria for data reported in 2010. They represent only 14% of the universe of facilities that the Joint Commission accredits.

These hospitals had a 95% score on a composite measure for all 22 performance measures for heart attack, heart failure, pneumonia, surgical care, and children's asthma care. The hospitals also met a second 95% target for each individual measure, which means "a hospital provided an evidence-based practice 95 times out of 100 opportunities to provide the practice," according to the Joint Commission.

The 405 that made the cut were primarily smaller and rural. Dr. Mark R. Chassin, president of the Joint Commission, in a briefing with reporters, was asked why some of the bigger and better-known academic and urban medical centers, all having stellar reputations, did not achieve the ranking of a top performer.

"I would suggest asking [those hospitals] why they think they're not on the list," he replied, noting that "Reputation and performance on important measures of quality don't often go together."

Dr. Chassin said that the Commission's use of process measures, instead of outcomes measures, was the best way to determine quality of care. "The criteria we've come up with are designed to make sure that the processes we measure and the measures we use to measure them focus on processes that have an extremely high likelihood of creating good outcomes," he said.

Overall, hospitals are doing much better at meeting these measures, said Dr. Chassin. But he added, "Hospitals can and should do better."

Among the improvements tallied by the Joint Commission in its annual report on quality:

- Hospitals provided an evidence-based heart attack treatment 984 times for every 1,000 opportunities to do so, for a composite score of 98.4%. That's up from 86.9% in 2002.
- The pneumonia care score rose from 72.3% in 2002 to 95.2%.
- The surgical care score improved from 82.1% in 2005 (when it was added) to 96.4%.
- The children's asthma care composite rose from 79.8% in 2008 to 92.3% in 2010.
- A total of 91.7% of hospitals achieved 90% or better on the overall composite score, up from just 26.2% in 2002. ■

VIEW ON THE NEWS

Quality Is in Outcomes, Not Process

Given that the "quality" we are talking about here is measured by process documentation (not actual outcomes), the smaller the hospital and number of documenting physicians, the more likely you are to see percentages of "quality" in the upper echelons. In other words, the process may be occurring in the larger hospitals, it is just not getting documented as such ... smaller hospitals can create uniform documentation standards a lot faster than larger hospitals.

It is a bit disingenuous for Dr. Chassin to suggest that reputation and performance do not often go together.

In the case of the Cleveland Clinic, Johns Hopkins, Duke, and other similar centers, it most certainly does and has been demonstrated in direct outcomes measurement.

You will notice that Lakewood Hospital in Lakewood, Ohio, is the only Cleveland-area hospital that is in the upper echelon in process measurement for acute myocardial infarction as listed by the Joint Commission (as it is, Lakewood Hospital is owned by the Cleveland Clinic and is a member of the Cleveland Clinic Health System), but if, because of this "best of the best" list, a complicated patient with an acute MI chooses to go to Lakewood Hospital over going to a tertiary center with outcomes reported as good as the Cleveland Clinic main campus, then the Joint Commission should be ashamed of itself.

FRANKLIN A. MICHOTA, M.D., is director of academic affairs in the department of hospital medicine at the Cleveland Clinic.