Presidential Address

Quality Assurance and Medical Stupidity

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"WHEN I USE a word, it means just what I want it to; nothing less, nothing more." These words from Lewis Carroll[1] suggest a philosophy that must have had more influence on medical writers than their teachers of English did. What other reason could possibly explain our ready acceptance of such strange cliches as the following, which were collected by Lois DeBakey from published medical writing[2]:

"The patient was throwing emboli."

"Both the patient and the physician were blinded during the experiment."

"A pelvic examination was done on the floor."

"The intern had noted that the patient was unresponsive in bed."

Unfortunately, the same disregard for precision in the use of language extends to writers of television scripts and political speeches. Perhaps that is why we accept, and even adopt, awkward and ludicrous examples of evasive language and circumlocution, such as:

"in close proximity" meaning "near";

"he was selected out" meaning "fired";

"terminated with extreme prejudice" meaning "killed."

Such usage becomes dangerous when it develops into "doublespeak," and the words express the opposite of what we mean. The classic example, of course, is the "Peacekeeper Missile," a destructive force for waging war.

More subtle examples of doublespeak creep into our medical vocabulary daily. We have departments of "customer relations" and "risk management." We have "23-hour stays," meaning that patients come to the hospital, have a procedure, and sleep overnight in a hospital bed—but they are "outpatients," not inpatients. Technically, they were never "admitted" to the hospital. This kind of ruse, which we have dignified with high-sounding phrases, lulls us into going along with what may be the worst example of doublespeak: Quality Assurance. The notion that a doctor or a hospital can "assure" the provision of "quality" medical care is spurious, and the concept of having it done by setting up a bureaucracy on the basis of competitive bidding is flawed. The efforts toward "assuring quality" would make a good chapter to add to James Welles' book, "The Story of Stupidity."[3]

Welles points out that specialists in intellectual history have tended to view the development of the Western mind as a progressive triumph of intelligence over stupidity, which he defines as "the learned corruption of learning." Stupidity, he says, has been our constant companion throughout history; and he gives examples ranging from the steadfast refusal of the principal professor of philosophy at Padua to look through Galileo's telescope (for fear that what he might see would change his thinking?) to the war in Viet Nam. The review of many such examples shows that

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groups of people always have a tendency to sacrifice quality, and sometimes even genius, in favor of preserving a "cooperative spirit" and cohesion of the group. I believe that this tendency on the part of physicians has been a major factor in allowing us to reach the present state of medical stupidity concerning "quality assurance." Welles says that, "...stupidity is induced when systems that should check each other become mutually reinforcing. I believe that has happened with our attempts at "quality assurance." To examine this theory, let us consider some examples of the present attempts to assess quality, next some of the problems of that system, and finally some suggestions for change.

Assessing Quality

Initially, the emphasis of organizations concerned with quality was on necessity for hospitalization; and while one can hardly argue with the concept of avoiding unnecessary hospitalization, implementation of the control mechanisms has taken some interesting twists. For example, the ruling that hernias in Medicare patients in Michigan must be done on an outpatient basis (except in well-defined complicating circumstances) resulted in a 50-year-old man spending the night after hernia repair, hospitalized as an "inpatient," while his father was sent home after the same procedure because the regulation precluded the older man's admission! As a result, hospitals developed "23-hour stays,"—the events remained the same, but the name was changed.

Although most surgeons and hospitals have adjusted to being forced to schedule hernia repairs in older patients as outpatient procedures, "certification" of the requirements for admission still causes some interesting problems. For example, one of our surgeons saw a Medicare patient with an incarcerated hernia in the Emergency Center, sedated him, reduced the hernia, admitted the patient, operated on him within 24-hours, and sent him home the following day. Three months later he, the hospital, and the patient were told that payment would be denied because the admission was not necessary. To the reply that observation for signs of compromise of viability of the bowel was standard of care, a second reviewer repeated the denial, as did a third reviewer who was allegedly a surgeon. Because of his strong feelings about principles, the operating surgeon requested a hearing by an administrative law judge; fortunately, the denial was reversed. In matters like this, related to necessity of admission, at least the issue is clear: money. Decreasing numbers of admissions may decrease expenditures. But if money is the issue, why are we calling it "quality assurance"?

More recently, the emphasis has been broadened from certification of necessity of admission to examination of details of the care provided. The Michigan Peer Review Organization (MPRO) adopted a system of assigning points to physicians and hospitals when they perceive a "quality problem." A level one sanction carries one point and relates primarily to documentation. Level two means that the reviewer believes there was a potential for harm to the patient and carries a penalty of five points. Level three, 25 points, means that the reviewer believes there was inappropriate care, which resulted in an adverse outcome. A physician who accumulates 25 points in a quarter may be denied participation in the Medicare program and may have his or her practice reviewed by the licensing agencies. I suppose it's akin to earned run averages for major league pitchers; I hope we don't see publication of the standings! Everyone is in favor of high-quality care, but is the system assuring it? Several examples give me reason to doubt.

A 75-year-old man with known widespread prostate cancer was evaluated in the Emergency Center for a swollen leg and subsequently admitted for possible venous thrombosis.

A phlebogram was interpreted as normal, however, and he was discharged in accordance with his wish to spend as much time at home as feasible. He was called back for admission a few days later because review of the phlebogram showed subtle findings that were compatible with venous thrombosis. Definitive studies, however, showed no clot. Instead, they showed compression of the iliac vein from a mass of tumor-filled lymph nodes. He was in near-terminal condition and remained in the hospital until his death 4 weeks later. The case was cited as a level three problem (25 points) for both the physician and the hospital. The hospital was cited because its employees supposedly interpreted the first venogram wrong, and the physician because he should have been suspicious of the negative report because the leg was swollen. Furthermore, since the patient was "inappropriately" discharged, payment for the readmission was denied! The ruling was reversed, of course, because there were no problems with quality of care.

In another situation, a patient came to the hospital because of a variety of symptoms, including fever and hemispheric transient ischemic attacks. A significant urinary tract infection was found and treated promptly, and angiograms showed an appropriate carotid artery plaque that was thought to be the cause of the neurologic symptoms. Carotid endarterectomy was done, with no complications and with cessation of the transient ischemic attacks. On the second postoperative night, a hemoglobin determination was done before

discharge the next morning. This was done to insure that there was no need for transfusion in this elderly patient with recent infection who undoubtedly had some coronary atherosclerosis and had undergone a vascular procedure. The results were normal, but the white blood cell count was elevated, even a little more than preoperatively. The patient had received antibiotic prophylaxis at surgery and had no systemic or local signs of infection. He was discharged with a documented plan of follow-up, which included evaluation by the vascular surgeon and by the urologist who, after a reasonable interval, admitted the patient for a transurethral prostatectomy as definitive treatment for the cause of the initial problem, urinary sepsis. The vascular surgeon was issued a level two sanction for failing to do further investigation of the cause of the elevated white blood cell count. He protested, of course, but a second reviewer upheld the judgment of the first, letting the five point penalty stand. In contrast to issues concerning necessity of admission, there is no appeal on issues of quality. Recently, I met with the surgeon, an associate medical director, a utilization review nurse, and an attorney to help draft a request to reopen this case for a third review. Whether we will be successful even in having a hearing, I don't know; but two things are apparent: 1) we spent a lot of time and money, and 2) we have done nothing to affect the quality of the medical care, which was excellent in the first place.

The stories could go on: a patient acquires an inflammatory "phlebitis" from an intravenous catheter, it is coded as a nosocomial infection, and the hospital is assessed one point in accordance with a ruling that each nosocomial infection is worth one quality point. If that practice persists, all large hospitals with reasonably adequate records of nosocomial infections will soon be defending their licenses!

MPRO is not alone in its quest; many of our surgeons recently received letters (usually three pages) and data sheets (about 20) notifying them that they were "overutilizers." On page one, the letter states that the information is not meant to imply that issues of overutilization exist; in the next paragraph, the surgeon is told that "variances" in his pattern of utilization have, indeed, been identified. An orthopedic surgeon, for example, who limits his practice to surgery of the hand was told that he was doing much more hand surgery than his peers; this is "overutilization"?!!

Problems of the Systems

All systems thus far developed to "assure quality" have a number of obvious problems, including a clerical staff with marginal medical knowledge, a nursing staff oriented more towards creating paperwork than understanding medical dilemmas, and doctors who remain anonymous while making judgments as peers. Since these reviews take place after care is rendered and are made from hospital charts—which I believe are generally inexcusably poor as documentation of patients' progress—it is not surprising that there is confusion about what is happening and why.

Even the premise that one can reliably detect adverse comments due to substandard care is faulty because of our inability to measure outcomes, a point agreed upon by most economists interested in such matters. Meyer, for example, states, "The troubling but honest answer ... is that we really do not know what we are receiving."[4] Enthoven says, "Nonphysicians *used to think* that there were well-established scientifically based standards for medical practice"[5] (emphasis mine). But the two "systems" involved are mutually reinforcing. Quality assurance organizations provide jobs for clerks, desk work for nurses, and supplemental income for a variety of physicians. Medical practice, however, does not change because doctors and hospitals learn the rules of the game and respond predictably; and that is where stupidity sets in. Unfortunately, this thinking is influencing our professional specialty societies, many of which are busy writing "practice norms" that will probably do little more than add to the bureaucracy, preserve the status quo, and quash, or at least delay, innovative changes in practice.

Whether the premises are faulty or not, a conclusion has been drawn: we will have utilization review, certification of medical necessity, managed care, and federally mandated peer review organizations. The latter are established by a process of competitive bidding for contracts of 3 years' duration; their staffing and their budgets are considered confidential information; and they are given the mission of determining whether "the quality of care meets the standard of care." They must find problems; otherwise, they lose their jobs. All this in the face of conclusions from our most prominent health economists who state that, "Systems performance cannot be easily measured because of our inability to measure health outcomes."[6] Even Enthoven believes "... it is too costly, if not impossible, to detect and control the behavior of doctors who are motivated to defeat the utilization control system... The indications for care are too numerous, too uncertain, and too changeable for a police force of reasonable size to keep up."[5]

If the existence of the police force cannot be changed, at least its costliness must be publicized, as was done recently by Sequoia Hospital in Redwood City, California. It cares for an average of 250 inpatients a day, spends 7.8 million dollars annually, and maintains 140 full-time employees just to deal with

regulating bodies and government-mandated paperwork. Whereas Sequoia Hospital's numbers of inpatients have not changed since 1966, their staff has increased by 175 per cent; they have ten full-time employees in utilization review, compared with zero in 1966, and 41 in medical records, compared with 17 in 1966.[7] Their experience is probably average—our hospital, which has as high standards of care as I have seen, will soon employ one nurse on a full-time basis just to handle appeals! When MPRO has a practice of having a clerk note every abnormal lab test done on the last day of hospitalization and issuing a level I quality sanction if the progress notes don't mention it, what else can be done? If all the nurses working for hospitals in utilization review, those working for peer review organizations, and those working for managed care plans could be put to work caring for patients, we would eliminate any nursing shortages overnight. And if the budget of the Michigan Peer Review Organization is 11 million dollars annually, are the taxpayers getting a reasonable value for their money? More importantly, is it doing anything to benefit the patients? If the answer to this latter question is no—and I believe it is—something must be changed; our costs for health care are too high to allow expenditures that do not benefit patients, especially under false pretenses.

What Can Be Done

If the message thus far sounds like a call to return to the "good old days," it is misinterpreted. When nearly half the amount of health costs are borne by the government, bureaucracy is here to stay; but some things can be done.

First of all, doctors need to take the lead in publicizing the costs of review and inequities in the systems. All of us need to write our congresspeople and our professional societies two kinds of letters. The first should be a brief, calm, and rational request for four things:

1. Budgets for peer review organizations should be published in local newspapers regularly, as should the numbers and categories of personnel employed by them.
2. Congress should mandate a mechanism for appeal on decisions concerning quality. There is no precedent I know of for a primary reviewing body to act as the sole judge in a matter that may affect an individual's right to earn a living.
3. Congress should mandate that physician reviewers' names be disclosed when level two and three sanctions are issued; they already have immunity from prosecution by existing law.
4. Congress should require an annual review of activity, which would include the number of quality sanctions issued (by level), the number rescinded, and the number confirmed.

The second type of letter should be written by every physician every time he or she receives a potential quality sanction. He or she should review the matter with the hospital staff first, outlining the details of the problem and the reasons for the actions; a copy should go to the patient, as well as to appropriate members of congress. Unless we get the attention of the voters and their elected representatives, we will be doomed to play paper games with the bureaucracy and watch as funds needed for patient care are wasted on matters that increase costs instead of "containing" them and, of course, have little to do with quality.

Progress in changing laws is pretty slow and frustrating, and some other things should be done simultaneously. *We have got to clean up our own act!*

Start with medical records. Like it or not, the chart is the record of the care rendered, and it is used for judging both its quality and the adherence to existing standards. In many instances, orders are hard to decipher, signatures are illegible, and progress notes do not relate the progress, much less disclose the reasons for changes in therapy. We use initials for words and allow an ever-expanding list of abbreviations to be used in orders. Does "IVP" mean "intravenous push" or "intravenous piggyback"? Or was the patient supposed to have an intravenous pyelogram? Discharge summaries are exhaustive compendia of numbers and reports, giving far too much general information, very little of which is pertinent to the critical features of a major illness. We store every piece of paper collected in the chart, although the odds of most of it being useful even for legal review are small. It is time for doctors to make their entries in the medical record brief, legible, and pertinent to the findings and to the decisions that affect care and the patient's course. We must insist on having appropriate records, and hospitals must be our allies in obtaining them.

Second, we must change some rules. Until recently, Beaumont Hospital required "a complete history and physical examination" before any operative procedure could begin. Does a 25-year-old, healthy woman having outpatient removal, with local anesthesia, of a breast mass, which was discovered a month ago by her gynecologist at the time of her annual Pap smear, need another pelvic exam? Does she need a review of systems? Of course not. Such patients' charts usually have a "short form," a printed form with blanks which,

in turn, are filled in with "0" and "neg." Is this of any value? No. We developed such habits when all outpatients were healthy, and their procedures simple, which is no longer the case. We must change our rules to indicate that all patients must have preoperative assessments appropriate to their scheduled procedures and their health status. An insulin dependent diabetic with cardiac and renal disease needs a different assessment before ophthalmologic surgery than that given to a 19-year-old football player before an arthroscopy. Physicians experienced in doing the operations are the ones who must set these standards. A blanket ruling that all surgical outpatients have their blood pressure taken in the supine position (and recorded, of course,) within an hour of the operation—as was apparently proposed by the Michigan Peer Review Organization—is inappropriate. But if working surgeons do not set the standards, we will have to accept them from someone else.

Third, after we change some rules, we must enforce them. If we allow outpatient surgery to be done without a traditional "H & P," and if we design a simple form that contains the pertinent and necessary information for scheduling, for preanesthetic evaluation, and for administrative purposes, we must insist that it be filled out legibly and completely, and signed. If not, the procedure should not be allowed to proceed. This ruling must come from your surgical service, so that your irate peers will not vent their spleens on the clerical and nursing staffs. Are you ready to enforce such rules?

Finally, it is time for the doctors to take the lead in developing programs that will monitor at least crude standards that reflect the consequences of treatment. Most hospitals know their nosocomial infection rates, but how many provide each surgeon annually with the (confidential) information of the rate of infections in clean cases on which he or she scrubbed, giving the department average for comparison? Very few, in spite of the fact that many studies show that prospective surveillance decreases the incidence of infection. You may know the percentage of gangrenous and ruptured appendices in your hospital, but do you even investigate the intervals between such patients' initial presentations and the start of their operations? Do you know the rate of leakage from colonic anastomoses, the mortality rate of elective aneurysmectomy, and the accuracy of your methods for diagnosing pulmonary embolism? Until we develop such programs *in concert with the hospital*, to assess our care, and until we show that we are willing to look for real problems and deal with them appropriately, we cannot expect to supplant programs imposed by those who pay our bills. If we decide to spend the time and meaningful effort to develop our own programs, they will be far superior to those we are flailing away at currently; and they will confirm that abuses, which we all deplore, do not, by and large, occur in major hospital settings. In addition, such programs can relate to the quality of care provided. Our selective surgical memories enhance our good results and suppress the bad, even when we hear them at morbidity and mortality conferences. If we are comparing our measured statistics with the departmental averages, we will be like the foreman on assembly line #2, as described by Berwick in his article, "Continuous Improvement As an Ideal in Health Care."[8] We share the common interest of giving our patients the best care, and we share skills and lessons learned to further that interest. If we do not, we will remain on line #1 of "quality by inspection," where the foremen look for "bad apples"; and the attitude is only to play the game and prove we are not deficient. We know how well "quality by inspection" worked for the auto industry; why are we acquiescing to it for medicine?

In summary, the problem was best stated by Radovsky: "Today's society recognizes medicine as one of life's necessities and no longer as the exclusive domain of its practitioner's. Doctors, now one of many parties to health care, still have capacities, insights, and interests that are unique. It is up to them to decide whether, how vigorously, and to what end they will stir themselves up to act in their own behalf."[9] Current systems of "quality assurance" are poorly conceived, improperly named, unreasonably constructed, and therefore ineffective; but they won't warrant a chapter in the books on stupidity unless doctors and hospitals continue to cooperate by viewing them as games. We must call attention to their problems, but we must be even more active in developing systems jointly with our hospitals that monitor measurable standards and make authentic efforts to encourage continuous improvement in the care provided. We should have done it long ago! And to those who liken such systems to foxes guarding chicken coops, I say that at least the foxes recognize the chickens; I cannot say as much for current organizations charged with recognizing quality.

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