How hospitalists and cardiologists partner to care for MI patients

To read the literature about treating heart attack patients is to dive into a bowl of alphabet soup. Each study has its own acronym, such as MIRACL, CHAMP, ASSENT, GUSTO, PRISM, OPTIMALL—the list goes on ad infinitum. But every one of those studies has been instrumental in educating physicians about the best ways to help a heart attack patient survive not just past the initial hospitalization, but afterwards as well.

In a study in the October 2006 Clinical Therapeutics, hospitalist and HMA editorial board member Alpesh Amin, MD, writes about ways hospitalists can better manage their patients with acute myocardial infarction (MI), particularly those with left ventricular dysfunction. In his article “Improving the management of patients after myocardial infarction, from admission to discharge,” Amin reviews existing literature and devises a list of recommended guidelines.

The recommendations are for aspirin, beta blockers, clopidogrel, angiotensin-converting enzyme inhibitors, heparin, and...
and glycoprotein IIb/IIIa inhibitors for patients undergoing a percutaneous coronary intervention. At discharge, patients should receive all of these treatments, as well as statins and aldosterone antagonists. Smoking cessation counseling and cardiac rehabilitation should also begin at discharge, when appropriate.

Hospitalists are well-positioned to ensure that MI patients get the best of evidence-based medicine, Amin writes. “Through their involvement in the design of patient support-care systems that include nurses, pharmacists, and other healthcare practitioners, hospitalists are in a position to lead implementation of programs.”

The profession is uniquely qualified to champion use of pathways, checklists, and algorithms to improve outcomes for these patients, Amin continues.

**What cardiologists want**

Although Amin’s study tells hospitalists what the literature wants for MI patients, what is it that cardiologists want out of hospitalists? Mun K. Hong, MD, director of interventional cardiology at St. Luke’s Roosevelt Hospital in New York City says that creating a partnership between hospitalists and cardiologists is key to making any program work.

“I want hospitalists to know that they have to learn as much as they can about the manifestations of coronary artery disease,” he says. “If there are pathways at your hospital, familiarize yourself with them. Know when to call a cardiologist.”

If your organization hasn’t adopted protocols, the hospitalists should get together with the cardiologists and create some, says Bill Getchell, MD, MPH, FACC, a cardiologist at Eastside Cardiology Associates in Kirkland, WA. The protocols will depend on the specifics of your location, hospital, and patient base. “Every hospital has to develop its own way to determine what it wants and what its people are willing to do,” Getchell says.

At Evergreen Hospital, also in Kirkland, where Getchell practices, there is no elective angioplasty, just emergency intervention for MI patients. For those patients who come in through the emergency department (ED), there is no interaction with hospitalists at all—they go from diagnosis of an MI directly to the cath lab. If the ED knows the patient is coming in with a likely MI, a cardiologist meets the ambulance and takes the patient directly to the cath lab. In addition, cardiologists solely handle follow-up for uncomplicated cases. However, for the many patients who have complications or who have secondary diagnoses (e.g., diabetes), the hospitalists play a key role. “They get involved immediately in complex cases,” says Getchell.

For cases in which there is no clear MI, the hospital uses the protocols and pathways that Amin’s paper reports are key to improving MI management. Together with the hospitalists, the cardiology group developed the protocols several years ago.

“Whether they go to the hospitalists or to us depends on a number of issues—such as what the ED is like, whether one physician is free and one is busy, or if the cardiologist is in the cath lab and unavailable,” Getchell explains. Regardless of whether the patient is treated by a cardiologist or hospitalist, he or she gets the same care.

For example, low-risk patients are put on a monitor, given aspirin, beta blockers, and nitro, as needed; and scheduled automatically for follow-up enzyme tests, a stress test, and continued monitoring. Intermediate-risk patients get lipid-lowering therapy, as well as an option for catheterization if needed. High-risk patients who have had a previous MI get all of those things done, and anyone who rules in for an MI is seen by a cardiologist.

The guidelines followed by cardiologists and hospitalists at Evergreen were developed from the American College of Cardiology guidelines on management of MI, but tailored to the local practice. “If I have one piece of advice, it is to not just do what someone
else’s guidelines,” Getchell says. For example, we have an early invasive program that has been borne out over several years by our data. If there are borderline troponin levels, we take them to the cath lab. We are more aggressive than a lot of hospitals are—we do it in the first hour, not the first 48 hours—and we have great outcomes.”

Internally, the hospital monitors the time from when patients arrive at the ED to when they have angioplasty. The hospital uses a confidential state database to check their outcomes for cardiac surgery and interventions against state benchmarks. If the data show some data set is sliding, Getchell says they will tweak the protocol. Indeed, it’s something they do fairly often. “It isn’t just that we developed the protocol and then we were done. We argued about it. We put out new versions,” he says.

Getchell says hospitalists and cardiologists meet with other hospital leaders every other month to determine what is working well with the MI protocol, as well as other programs. “We talk about everything—what to do differently, what new quality initiatives we should pursue. We have used what we did for MI to branch out into a heart failure program,” he adds.

So far, so good. HealthGrades’ 2007 rankings list Evergreen Hospital as number one in the Seattle area for MI care.

St. Luke’s pathways are different than those at Evergreen, says Hong. Low-risk patients go to a regular floor, whereas high-risk MI patients go to the cardiologists. St. Luke’s hospitalists and cardiologists, like those at Evergreen, based their guidelines on the literature. But they change them as needed so that they make sense to their hospital and patients. For example, they have streamlined processes so that as soon as a patient hits the ED with a suspected MI, cardiology gets a call.

Hospitalists are great at taking care of immediate problems, says Hong, and because of the work that St. Luke’s has done on getting them involved in the pathways early on, they also know when it’s time to call an appropriate subspecialty.

“If there is chest pain with previous revascularization, call the cardiologist and address problems as you need to until they arrive. Don’t treat the chest pain, don’t try to rule out other things. Get us in fast,” he says.

**Following the path**

The key to successful hospitalist/cardiologist partnerships for treating MI patients is more than education, says Getchell. “It’s about human nature. We forget stuff. You have to create ways to assist without being overbearing,” he says.

Further, hospitalists and cardiologist must work together to create protocols that acknowledge that every patient is different. “Be flexible, but say why you are being flexible,” he advises. “Whatever protocol or tool you use to help you, it should make doing the right thing the easiest option, and doing something different harder. It should be an opt-out program, not an opt-in.”

But making those opt-out rules too strict won’t work—that’s a lesson Getchell and his colleagues learned the hard way. Initially, protocols were strictly enforced, which made it difficult for physicians to properly treat some patients. “It was hard to deal with a situation where you had a patient on beta blockers already, and you were supposed to give them another,” he says. “We had to loosen some of the rules a little because no protocol will work for every patient.”

Lastly, someone—be it cardiologist or hospitalist—has to champion whatever program you decide to implement. “And whoever that is . . . [has] to be willing to let go and allow changes to be made to meet the needs of your facility and your patients,” Getchell says.

Pathways and protocols are vital to treating MI, Hong concludes. “We have a lot of studies that support what we do. It makes it easier for all of us to do the same thing.”

*Editor’s note: For more information on this topic, contact Getchell at bgetchell@eastsidecardiology.com or Hong at 212/492-5550.*
16 physicians work nights and weekends—because a physician is always on hand during the day—and they don’t interact with hospitalists at all.

That suits the hospitalists just fine, says Russell, noting that most non-OB physicians will avoid a laboring patient like the plague no matter what other conditions she presents with. An OB hospitalist is probably best suited to work alone, she adds. But in a large hospitalist group working at a big facility with a lot of deliveries, there might be room for an OB hospitalist.

A gastroenterologist program
Other physicians have the potential to fit more seamlessly into a mature hospitalist group, expanding its scope of expertise and potentially the business it does. Consider the gastroenterologist hospitalist program of six hospitals in Tacoma, WA, and Knoxville, TN.

Started about nine years ago, the program was recently featured in the October 2006 *Gastrointestinal Endoscopy Clinics of North America*. Harald Schoeppner, MD, of Tacoma and his colleague Stanley Miller, MD, of Knoxville describe their program, which averages eight to 12 procedures per day, and as many as 28 patient contacts—new and existing combined. About 10% of those patients are admitted to their own service, with the rest of the consultations coming from hospitalist or subspecialty groups.

“We were having an issue pulling people out of freestanding ambulatory surgery centers to provide hospital coverage,” Schoeppner says. Each physician in the gastroenterology practice was covering rounds for a week and taking call one day per week. “You were running from outpatient practice to the hospital to put out fires. There was no consistency.” Some physicians were better at the inpatient work and enjoyed it more, he adds.

The rationale sounds similar to what led to general hospital medicine in the first place. “There were a lot of inefficiencies. A lot of hours were spent in the hospital dealing with emergencies. We thought this would be better to improve the quality of life for the physicians and provide better care for patients. You gain experience by being there [in the hospital] and having a routine,” he says.

His role as a gastro-hospitalist is to do expert procedures and provide opinions on procedures. “I [treat] a number of patients from our own clinics, too,” Schoeppner says. Although general hospitalists can take on most of the hospitalized patients, he and a colleague who also does inpatient work can take more complex patients who need complicated procedures or who have conditions such as severe pancreatitis, inflammatory bowel disease, or internal bleeding. According to his article, about 15% of the work is elective endoscopic retrograde cholangiopancreatography, endoscopic ultrasound, achalasia balloon dilations, and dealing with variceal banding.

Currently, his own outpatient practice patients and the cases on which he consults keep him busy enough, but Schoeppner isn’t sure whether a traditional hospitalist program at most hospitals would have enough work. That said, volume increased by 30% the first year of the program in Tacoma and by a similar amount at the practice in Knoxville. It is, he says, a case of “if you build it, they will come.” For a physician who is interested in doing a lot of procedures, it’s a great job, says Schoeppner. Gastro-hospitalists can help with obstructions, liver disease and its complications, and feeding problems in the intensive care unit (ICU).

The gastroenterology group, not the hospital, pays him; his physician colleague; the physician assistant who handles histories, discharges, and family communication; and the nurse coordinator. And that group of physicians is happy to do so, because not being in the hospital means they can do what makes them the most money—outpatient ambulatory procedures—rather than focusing on inpatient work on sicker patients.
Fits just right

One of the better fits with an existing hospitalist program might be a laryngology hospitalist. **Paul Castellanos, MD,** of the University of Alabama in Birmingham first started such a program at the University of Maryland Hospital System. When he moved to Alabama, he brought the program with him. Castellanos wrote about the program in the September 2005 *Journal of Voice.*

Part airway surgery subspecialist, part hospitalist, Castellanos says having such a program offers everyone—hospitalist groups, hospitals, and patients—benefits. Often, he can prevent airway issues that lead to complications, readmissions, or even death. He can also handle critical issues that come up. For example, in late January, he was called to the surgical ICU to handle a tracheal blood clot that the cardiothoracic surgeons couldn’t manage. “I did a bedside procedure right then and there, and that patient lived. If I had not been there, it would be relegated to a physician on call, who might be an [ear or nose specialist]. What that patient needed was an airway specialist.”

Not that he thinks of himself as some kind of superhero. Rather, Castellanos says he is just the “go-to person for airways. I can bring tools to the bedside that others can’t, and I’ll take on patients even though they might die.”

Among the cases for which he is called in are failed extubations, which often have reasons for failure that can’t be easily discovered.

“It is a perilous situation. You may succeed on second effort or you may not. In many cases, the physician will proceed directly to the tracheotomy just to avoid a second failed extubation,” he says. But if you can figure out the reason for the first failure, you are more likely to succeed on a second time. Get a laryngologist in to consult—if one is available—and you might be able to avoid a tracheotomy.”

Laryngology hospitalists can also handle aspiration problems, which can help to decrease the cost of an entire episode of care. Rather than discharging a patient without determining the cause, which could lead to readmission, a laryngology hospitalist might determine that it is a granuloma or a minor obstructing tissue causing a patient’s problem. “Then you don’t need to do a tracheotomy or the workup for it,” he adds.

Castellanos says there is plenty of work for him to do at the 1,200-bed facility, although he only spends half of each day in the hospital and still maintains a private practice. A similar hospital would likewise have plenty of work for a laryngology hospitalist. “It would bill terrifically, too, and would offload significant drains on time and increase the safety with which the patients are treated,” he says.

Castellanos believes that there actually is enough work for three physicians—two primary and one trainee—and hopes the laryngology hospitalist program will be that big within the next six months.

But even one specialist can benefit a hospital, he notes. “It beats calling the on-call guy and finding out he’s a head and neck doctor who doesn’t know how to restore an airway,” he says.

A win, win, win

A trial program would be cheap and easy to start, he says. All you need is an endoscopy cart. Even if there were higher costs, it would be worth it, he continues.

Hospitals will benefit in costs saved by keeping patients out of the ICU or reducing the potential for litigation over an impaired or brain-dead patient resulting from a failed airway rescue attempt.

Physicians at the hospital love the expertise, the patients have expert care, and the hospital will see more surgery at the facility because of postdischarge referrals. It’s a win-win-win scenario, he says.

Will the future bring other hospitalist specialists? Probably. And although some will merely use the word hospitalist along with their specialty name, others will be able to work well within or in conjunction with traditional hospitalist programs.
Create a fair system to solve ED call dilemma

Lack of specialist backup is a concern to hospitalists

If you’re having trouble finding a subspecialist to consult in your emergency department (ED), you are not alone.

According to a report in the December 2006 Health Affairs, healthcare organizations in three-fourths of the surveyed communities are having trouble getting specialists to handle ED call. The price of malpractice insurance, decreased remuneration for call, and the unpredictable hours are among the reasons why surgical subspecialists, in particular, are refusing to take call.

Roger Heroux, PhD, a principal with Hospitalist Management Resources, a consulting firm based in Del Mar, CA, says if hospitalist leaders and the hospitals at which they work don’t address the problem, they will quickly find it harder to recruit and retain hospitalists. “We have heard many hospitalists express concerns about this,” he notes. “One reason they are leaving a particular program is because they could not be assured of specialty backup.”

In the past couple of years, Heroux and his partner have consulted at more than 50 hospitals in every region of the country regarding this problem. “The problem is only getting worse,” he says.

Although mandatory call would solve the problem, many hospitals have opted to change to voluntary call panels. “Then no one wants it; or if they do it, they demand payment,” he says.

A costly problem

Implementing a hospitalist program certainly solves part of the problem—hospitalists can handle as many as half of the patients that come through the ED. However, establishing a hospitalist program will not solve the problem of treating the 50% of patients who require a consultation by a specialist.

Some hospitals deal with the issue by paying large sums of money for physicians to take call. The Health Affairs article reports that the surveyed hospitals reported paying about $1,000 per day for ED coverage in some critical specialties, such as neurosurgery. One hospital reported paying $10,000 per week for ED coverage and 120% of Medicare rates for uninsured trauma patients.

Keep in mind that if your organization chooses to pay the neurosurgeons one rate and gastroenterologists another, you can’t assume that the different rates will remain confidential. “If you have one neurosurgeon and you are paying him $2,000 a night and tell him not to say anything, eventually everyone will know, and everyone will want that kind of payment,” Heroux warns.

Look for equity

The best approach is to be collaborative and transparent, he says. Hospitalists who have this problem at their facilities would be better off suggesting a compensation system based on relative value units (RVU) and current procedural terminology (CPT) codes. “You will have to pay [the specialists], but you want it to be fair and equitable, as well as financially viable in the long run,” he says. Heroux suggests a program that is geared to 100% of Medicare rates for all unassigned patients. Have the specialist bill with CPT codes and RVUs. It’s transparent and fair, and the more the specialist takes call, the more money he or she makes.

You can even help your facility determine the financial effect of this arrangement by examining the frequency and acuity by subspecialty, he adds.

“There is no perfect solution,” Heroux admits. “But it is a complex issue that is not going away. What is important is to create a system that staff like, support, and [are] willing to participate in. That will make life better for the hospitalists and the patients.”

Editor’s note: For more information on this topic, contact Heroux at 858/481-7108.
Resolve bottlenecks by improving the discharge process

Hospitalists team up with hospital leadership to promote change

People often point to the long wait times in the emergency department (ED) as the source of bottlenecks in the patient care process. However, the problems don’t always originate at the beginning of a hospital visit—the ED visit or direct admission—but rather at the end of the process at discharge. That is the lesson that Lehigh Valley Hospital in Allentown, PA, learned over a three-year period.

The hospital was experiencing what Terry Capuano, RN, MSN, MBA, senior vice president of clinical services, calls “humble” admissions growth of 1%–2% in the early part of the decade. “We were constrained by our capacity,” she says. “We had diversions in the [ED], holds in the [operating room], and we were turning away referral patients from other hospitals. Everything was bulging with demand.”

In 2001, the hospital administration made it a priority to solve this growing problem. It began to tackle the issue by taking a good long look at its ED. “But no matter what we did for wait time or length of stay, it didn’t help,” Capuano says. Although the ED felt like a logical starting point, leadership quickly learned it had to start at the end—the discharge process.

The hospital held a retreat with leadership from every department in the hospital. “There were several hundred people in a room,” she recalls.

Modeled after similar programs at Southwest Airlines, the group identified where they thought the problems lied. They worked in groups of about 10 and came up with more than 1,000 ideas. After the daylong retreat, a core group culled through them, looking for themes and areas of priority.

For example, one area that was repeatedly brought up was how long it took for a bed to be freed up after discharge. That became a priority, and the group looked for data surrounding the issue. “We broke it down to all the steps between discharge and having a clean bed ready for a new patient,” she says. Teams were developed to look at each problem.

Note: Initially, the hospital brought in a consulting group to help deal with the bottleneck issues. But leaders throughout the hospital felt that “we could understand our processes better than anyone,” says Capuano. “We knew if we could engage people in this process from the start, we would get the buy-in we needed to make any changes.” So they opted to do the work themselves, rather than pay a consultant.

Between 2003 and 2005, the hospital took on 17 projects aimed at reducing bottlenecks (for a list of the projects, see “Seventeen projects to address bottlenecks” on p. 9)—projects that could not have succeeded without the support of the organization’s physicians, particularly the 16 hospitalists who helped to break down barriers and resistance to change.

Over those years, admissions grew by 5%, 6%, and 8% respectively. “We have a new tower going up right now, and we wanted to bridge the gap for the five years between then and when it will be done. We aimed to have 5% admissions growth each year over those five years,” Capuano says. So far, so good.

The initial projects, such as the discharge-to-clean-bed program, were the “low-hanging fruit.” “We looked at what happens from when the physician writes the order and we say goodbye to the patient to when the next patient gets that bed,” she says. One group focused on preparing the patient for discharge. Another looked at how the patient got from the room to the door.

As a result of these early projects, Lehigh adopted the following changes to improve the discharge process and reduce bottlenecks:

1. Patient logistic system. Before Lehigh Valley examined and revised its discharge process, volunteers or staff from the unit were transporting patients. However, patients were often ready to go for a long time before someone came for them, Capuano says. The “process” is now a thing

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of the past. As a result of Lehigh’s initial projects, the organizations created a patient logistics system.

A transporter is now called, so no one from the unit has to leave the floor to escort a patient. When that person reaches the patient’s room, he or she dials a number that goes directly to a bed-board system, which logs in an empty bed and automatically generates a call to a cleaning SWAT team whose sole job is to clean beds for the next patient.

The SWAT team members dial the number when they arrive at a room, and again when they leave. The time it takes to clean various types of beds is monitored and compared to benchmarks.

When the bed is clean, it is noted in the bed management system. Anyone in the organization can access that system—from the ED to the operating room to units. “There was this myth that people were hiding beds. I don’t know how true it was, but even if it was, they can’t do it anymore,” says Capuano.

What used to take an average of 210 minutes to complete has dwindled to 60, and that figure has held steady for a couple of years now.

2. Improved ancillary services. The hospital also sought to improve the availability of ancillary services so that physicians could see test results early.

“We looked at staffing and hours of operation,” says Capuano. The organization also identified tests that are needed for discharge and prioritized those tests.

3. Modified rounds. When identifying obstacles to early discharge, the group noted that teaching rounds were delaying the discharge process. Although rounds had traditionally been done in the morning, the physicians were willing try a different way. “It had always been the sickest, the newest, the stable, and, lastly, the discharges. But they were willing to rethink how the resident rounds were done and consider timing them later in the day so that discharge orders can be written first,” says Capuano.

4. Physician extenders. Other physician groups were likewise willing to consider changes. The cardiothoracic surgery group hired a nurse practitioner to be on the units while they were in surgery. That extender helps get patients ready for discharge and handles tasks such as patient education. The group was able to shave 1.4 days off the length of stay in the past year and still have the best cardiac surgery outcomes in the state.

Hospitalists’ role

The message for hospitalists, says Capuano, is to take the lead when administrators start talking about bottlenecks. “Look at the back end first and get involved at every stage of the program. Understand your operations and how you fit into them. When you do, you can create a platform from which to lead. If you figure it’s someone else’s problem or someone else’s fault, you are wrong.”

Don’t assume that ED wait times have nothing to do with you, she says. Once you decide to act, listen to the physicians and engage them in the processes.

Lead by example, she says. “If you are part of the process, other physicians can’t throw stones and say no one else is doing anything, and they have to make all the changes.”

Don’t assume that processes that seem etched in stone cannot be changed, either, Capuano says. “Once people are engaged in the process they are much more willing to turn on a dime. When they see improvements start to happen and understand your commitment to the process, they are more willing to do some difficult things.”

It can’t happen without hospitalists, she adds. “They are a very engaged group who are very interested in improving systems. They are very busy. But they are always willing to do more.”

Editor’s note: For more information contact Capuano at 610/402-7510 or terry.capuano@lvh.com.
Seventeen projects to address bottlenecks

Following is a list of projects that Lehigh Valley Hospital in Allentown, PA, initiated to resolve bottlenecks in its patient care process.

1. Discharge process: Focused on physician communication and the nursing staff process of patient discharge

2. Transport mechanics for discharge: Designed centralized patient transport process for patient discharge to reduce delays in discharge process and bed turnaround times

3. External transport (centralized ambulance): Designed a centralized ambulance transport function to expedite, coordinate, and prioritize movement of patients to other care facilities and to reduce the number of extraneous phone calls required by case managers

4. Discharge bed turnaround time: Redesigned the reporting and process of cleaning dirty beds and the reporting of clean beds to reduce delays in bed turnaround times and availability

5. Bed tracking software: Designed a vendor-supported technology application to complement and accelerate the discharge bed turnaround process through real-time bed status reporting

6. Intrahospital transfers: Redesigned the process for transfer of patients within the hospital, including the design of the patient flow coordinator role

7. Short-stay hospital implementation: Implemented a short-stay hospital for one- and two-day stay ambulatory surgery, off-loading select surgical volume from the tertiary campus

8. Find-a-bed implementation: Without physically expanding, created additional capacity of 70 licensed beds by converting storage closets, offices, lounges, and waiting rooms into patient rooms

9. Expanded express admissions unit feasibility: Determined the feasibility of expanding the express admissions unit model to seven beds to expedite direct admission and off-loading of emergency department (ED) volume

10. Observation unit feasibility: Determined the feasibility of the operation of a universal unit for observation patients

11. Ancillary services feasibility: Determined feasibility of expanding ancillary services hours to facilitate patient discharge

12. Patient logistics implementation: Created a new function in patient logistics by stitching together six subprojects and implementing an integrated plan

13. Pull system: Designed and implemented an automatic “pull” system for patient admissions and transfers

14. Smoothing feasibility: Conducted a feasibility study to identify opportunities to smooth the flow of patients in and out of surgical and cardiac catheterization areas

15. Timely discharge: Tested discharge by appointment, distributed boxed lunches, and implemented a discharge time accountability reporting system for physicians to increase the percentage of patients with timely discharges

16. Shorten outpatient stays: Designed and implemented a collaborative rounding program and long-stay SWAT meetings, and recommended additional beds on the subacute care unit and transitional skilled unit

17. ED length-of-stay reduction: Designed and implemented ED process improvements to reduce ED length of stay

Source: Lehigh Valley Hospital, Allentown, PA.
Recruiting tip of the month: Include spouse in the interview process to improve retention

To determine whether your physician candidate is a viable prospect for a long-term fit, engage his or her spouse early in the recruitment process.

This will help you better understand the family’s dynamics, as well as the professional and personal needs of both parties.

Once you realize you’re recruiting the couple and not just the physician, you will be able to address the needs that each individual feels are most important.

The importance of family and spouse in recruiting and retaining physicians is reinforced by findings of a physician retention survey of group practice administrators.

The survey, conducted in 2006 by Cejka Search and the American Medical Group Association (AMGA), was completed by 92 AMGA members who collectively employ more than 16,833 physicians.

According to the survey results, relocating to be “closer to family” or “for spouse’s job” were among the four most frequently mentioned reasons why a physician leaves a practice voluntarily. The effectiveness of early engagement with a candidate’s spouse was also reinforced in the retention survey.

Group practice administrators noted the following as being effective strategies:

- Providing dedicated relocation assistance
- Including the spouse during the interview
- Providing career assistance or professional networking for the spouse
- Creating social events for the family

If the practice opportunity you are offering is especially unique due to location or the nature of the position, you may want to consider offering a one-week locum tenens as a trial. If you remember that employing a physician is often a package deal, and you work to make both partners happy, you’re more likely to employ a physician who will be with you for the long term.

Editor’s note: This tip was submitted by Paul Smallwood, vice president of physician search at St. Louis–based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.
Physicians and hospitalized patients have different
definition of medical errors and mistakes
What they think affects satisfaction, says study

What patients mean when they talk about a medical
error or mistake and what physicians mean by the
same terms may be two very different things.

Hospital patients define medical errors much more
broadly than the traditional clinical definitions of
medical errors, according to a study published in
the January Joint Commission Journal on Quality
and Patient Safety.

Many patients consider situations such as communica-
tion problems, responsiveness, and falls as med-
ical errors, the study found.

The findings point out the need for physicians and
other healthcare professionals to clarify what patients
mean when they talk about an error or mistake.

The study of more than 1,600 patients at 12 Midwest-
ern hospitals also shows the importance of explain-
ing exactly what is meant by the term “medical error”
if healthcare professionals are to effectively engage
patients in programs to prevent them.

Who has most patient concerns
The study by Thomas E. Burroughs, PhD, and
his colleagues concludes that most patients felt a
high level of medical safety, but 39% experienced
concern about at least a single type of medical
error during their hospitalization.

Certain groups of patients were more likely to be
concerned about medical errors, (e.g., middle-aged
patients and parents of pediatric patients).

In addition, patients who experienced longer lengths
of stay or more severe illnesses, or who were admit-
ted through the emergency department were likely
to experience more concerns.

Patients who received care in small and rural hospi-
tals reported the fewest types of concerns, regardless
of the severity of illness.

Burroughs notes that hospitals may need to tailor
their programs to educate patients to play a more
active role in preventing errors to effectively address
the fears and concerns of each patient.

Questions? Comments? Ideas?
Contact Executive Editor Erin Callahan

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“The study underscores that patients and clinicians can have different views of the things that constitute a medical error,” says Burroughs. “For patients, clear communication and responsiveness are particularly important.

If these are lacking, patients may view this as a medical error. It is important that clinicians recognize these differences and the importance of communication and responsiveness.”

Other notable findings in the study include the following:

- **Patient satisfaction.** A strong link exists between a patient’s concerns about medical errors and his or her satisfaction with the entire hospital experience. A single concern was tied to a significantly reduced likelihood of recommending and returning to the hospital for future care. It is important to note that these are concerns, and not necessarily actual errors. For patients, it appears that error-related concerns alone, even if not linked to an actual error, are enough to significantly affect their perceptions of the entire experience, which could alter their adherence and willingness to return for care.

- **Measuring concerns.** It is recommended that hospitals consider routine measurement of patient concerns about medical errors as part of patient satisfaction efforts. Ideally, such measurements would take place in real time, allowing healthcare providers to respond directly to patients’ concerns. Even if hospitals measure such concerns retrospectively, assessing patient fears about medical errors could guide ongoing quality improvement activities and help gauge the effectiveness of patient safety efforts.

- **Further exploration.** Additional research is needed into the factors that generate concern among patients about medical errors, how best to encourage patients to express these concerns, and what strategies effectively reassure patients about their medical safety. Incorporating patient attitudes into safety programs could help prevent medical errors and enhance patients’ satisfaction with their healthcare experience.