Letters

Forecast for osteopathic medical education programs in the for-profit hospital environs

To the Editor:

As the healthcare system in the United States continues to change, more hospitals are merging into for-profit hospital systems. This trend is continuing despite recent federal investigation into some for-profit systems for questionable billing practices, among other concerns. With the impending entry of the first for-profit hospital system into the state of Michigan, questions arise concerning the status of osteopathic primary care education programs for interns and residents in the for-profit hospital environment.

In searching the literature, I found no articles on this topic. Therefore, I embarked on personal discussions with directors of medical education, residents, hospital chief executive officers, and other hospital personnel to see how they're faring. I found primarily positive comments. Although some persons were unhappy about some of the corporate decisions, overall, most persons I spoke with expressed overwhelming approval.

Only one transaction in which a for-profit system bought a college osteopathic hospital elicited repeatedly negative remarks. Yet, as I gathered more information about this particular transaction, I've come to think that this negativity is really based on a series of misinterpretations, operational slip ups, and the failure to share complete information with all faculty and students. In this instance, things were done that caused confusion, but I do not think this is the usual scenario. In most outright purchases or even partnerships, personnel in the hospitals and colleges, as well as the physicians and residents, were pleased with the new arrangement; they viewed it as having a positive effect.

If anything, I get the feeling that for-profit hospital systems look favorably on osteopathic primary care medical education and its graduates, as they see us as good primary care providers. Primary care providers are, after all, a very important part of for-profit and not-for-profit hospitals.

Not specific to osteopathic medical education is the issue of cost efficiency with accountability, along with the ability to document good educational standards and outcomes. Accountability ranks important in for-profit hospital systems. Healthcare personnel must be ready to defend their budgets and programs. The days of small programs with one or two residents are probably over as are poor—or mediocre—internships and residencies.

Osteopathic medical training programs must be prepared to be judged against a national standard, including being able to compete with those Accreditation Council for Graduate Medical Education (ACGME)-approved programs that train osteopathic physicians. Establishing medical programs as bench marks, as well as setting standards for the quality of patient care and cost efficiency, is in progress.

The bottom line plays an essential part in almost all for-profit hospitals. Nonetheless, for-profit hospital systems support primary care programs. Specialty training programs are supported—if they can be adequately defended, are seen as needed in the hospital system, and are of high educational quality.

Osteopathic medical education should *not* be afraid of for-profit hospital systems. Like allopathic programs, osteopathic medical education programs will survive if they are quality programs that can justify their existence and show that they benefit the hospital system in ways that go beyond the bottom line and encompass the total operations of the system.

For-profit hospitals are a threat to the status quo. I do not fear them, however; rather, I see them as a breath of fresh air in a system set in its ways that fears *real* competition. Although a hospital's first priority is providing good patient care, the hospital is a business and should be run as such. Medical education is a part of that business and should be run as such. Likewise, universities and colleges of osteopathic medicine are businesses and should be run accordingly. Being accountable and able to justify a program's existence are reasonable expectations and are ones that we should be ready to meet.

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Examining quality improvement vs cost containment

To the Editor:

I was very interested in the article "Evaluation of a critical pathway for stroke" (*JAOA* 1997;97:269-272,275-276) by Gary Ross, DO, and colleagues. The authors reported their experience in creating a multidisciplinary task force to develop, implement, and monitor a critical pathway for the management of stroke patients admitted to the hospital. Because this hospital length of stay for this diagnosis was longer than that reported in the literature, stroke became a principal target for development of the critical pathway quality improvement project. After implementation of the pathway, a reduction occurred in the length of stay, and improvement was noted on a variety of performance measures.

I have no doubt that the reduction in variation achieved by implementing the critical pathway improved institutional efficiency and had potential to improve quality and patient outcomes. However, I question the original intent of this endeavor after reading the article. Was the team created to improve real or perceived problems with quality of care, or was the primary goal to reduce the length of stay? With the exception of length of stay, no other measures of patient outcome were reported. As Chassin[1] points out, "Much

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of what passes for quality improvement can justifiably be viewed as thinly veiled cost containment or marketing."

In the absence of measures of patient outcomes, improvements in processes of care that have been clearly linked by medical evidence to improved patient outcomes can be acceptable measures of quality.[2] Although a number of measures were reported in the article to *suggest* improvement of quality of care, most reflected documentation issues or were based on consensus guidelines without clear evidentiary links to improved patient outcomes. For example, the authors demonstrated increased utilization of carotid ultrasonography within 24 hours of admission and second computed tomography scan of the brain during the admission as a result of the pathway. I am not aware of evidence-based guidelines or randomized controlled trials that document a direct improvement in patient outcomes with the routine performance of either of these tests on patients with ischemic stroke. Therefore, I question whether these performance measures reflect improved quality of care. Either test may be indicated on a case-by-case basis,[3] but as with many diagnostic tests, disagreement exists among expert physicians with regard to indications. Both tests increase hospital utilization and costs.

The authors reported that improving patient care systems in the hospital was easier than prompting changes in physician behavior. In a recent lecture, Donabedian[4] reminded us that the indispensable first step in the process of quality assurance is a genuine conviction that performance needs to be improved. "Such conviction must exist in the organization, in the group, and, ultimately, in each individual, insofar as that individual's own performance is concerned."

I think most physicians want to provide good quality care. Given credible evidence that patient outcomes can be improved by implementing guidelines or pathways, physicians are more likely to participate actively in quality initiatives. Without that clear evidence, however, physicians can be justifiably skeptical of those initiatives, particularly when those

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promoting the quality improvement effort are perceived to be most interested in reducing the costs of care.

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Response

Your comments are well taken. As mentioned in the article, stroke was chosen as a diagnosis for the development of a critical pathway for two reasons. One, stroke is a high-volume diagnosis and two, a potential cost reduction was apparent. Once the decision was made that stroke would be the diagnosis for the pathway initiative, then patient care became the main focus.

During the development of the pathway, cost was not discussed. We assumed that focused patient care is cost effective and that length of stay is the primary cost determinant for stroke patients. Also, as you mentioned, improvements in processes of care can improve patient outcomes.

You commented that the "measures" chosen in the article may not reflect quality of care. Ongoing "outcomes measurements" take place within the hospital independent of the variance measures set up specifically to monitor pathway utiliza-

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tion. Mortality and readmissions are monitored for all diagnoses by the various quality assurance committees. No changes occurred in mortality or readmission statistics, as mentioned in the article.

The variances monitored were used as surrogate markers to good patient care as defined by the pathway. The pathway guidelines were based on the current literature and the consensus of expert opinion.

You mentioned that the increased use of ultrasound and computed tomography with regard to patient outcomes has no documentation in the literature. As such, the physicians who developed the pathway guidelines based the decision to include these parameters on their expertise. Our study did not evaluate whether such inclusion was a good decision based on patient outcomes.

The argument for increasing the utilization of carotid ultrasonography was based on the need to identify critical stenosis as soon as possible, thereby, intervening with endarterectomy *prior to* a future cardiovascular event. During the pathway development phase, a retrospective chart review of stroke patients was performed to see the percentage of patients thought to have carotid disease which would suggest the need for an ultrasound. The results were discussed with the neurologists who agreed that approximately 90% of our patients had indications to undergo carotid ultrasonography. For efficiency, the task force suggested all patients admitted for acute cerebrovascular accident (CVA) should undergo carotid ultrasonography. The standing orders were not included in our article; however, if a carotid ultrasound was performed within 3 months, it is not repeated. Instead, the patient's ultrasound report is placed in his chart.

The scan may not show changes of cerebral infarction for 24 to 48 hours from the time of the ischemia. The first scan was taken primarily to rule out a hemorrhage. The second one was taken to assist in a diagnosis—if the first scan was negative. This second scan was also used to see if there was extension of the stroke. As such, it was used to define a patient with "progression of CVA."

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CME quiz discussion

The following answers/discussions relate to the quiz appearing in the October 1997 issue of JAOA.

1. (c) Briminodine shows an increased selectivity for α_2-adrenoceptors, and this helps in decreasing its incidence of allergic reaction.

2. (b) Latanoprost causes a darkening of the iris color by increasing the number of melanosomes in hazel or mixed-color irides.

3. (b) Fluconazole causes leukopenia.

4. (d) Decreasing the dose of fluconazole reduces gastrointestinal distress. Rarely does fluconazole need to be discontinued because of gastrointestinal distress. Instead the dose should be decreased.

5. (d) Alcohol use disorders in US elders (>65 years) are predominantly manifested by atypical physical and psychological consequences. The prevalence of alcohol use disorders in the community elders is 3% to 5%, and in the family practice setting, 5% to 33%. Elders are more likely to be adversely affected by alcohol use disorders than younger adults owing to drug interactions, limited reserve in cognitive and physical functioning, and a higher blood alcohol level for the amount consumed due to a smaller volume of distribution. Although the Alcohol Module of the Diagnostic Interview Schedule is often considered the gold standard for diagnosis of alcohol use disorders, many of its criteria may not apply to elders who are often retired, widowed, or separated from other family members. In addition, withdrawal symptoms may be difficult to assess in elders. Previous studies have shown that physicians diagnose only about 30% of elders with alcohol use disorder.

6. (e) Both the CAGE and the AUDIT may be useful in screening elders for alcohol use disorders. In addition, NIAAA criteria for excessive alcohol conumption in elders may be a useful clue to those with alcohol use disorders.

7. (c) Although transmission of the infectious form of the coccidian or microsporidian agents of intestinal disease can theoretically be transmitted via food, only *Cyclospora* has been reported as having a strong association with this mode of transmission.

8. (d) Although light microscopy coupled with other techniques, such as histologic examination (plastic-embedded sections, et cetera), touch preparations of biopsy materials, and cytospin preparations, will demonstrate the spores of a microsporidian, more refined procedures are required for identification of the species level.

9. (c) The microsporidian is unique in terms of host entry. The polar tubule everts in proximity to the host cell. On contact with the receptive host cell, an entry channel occurs, and the parasite protoplasm enters the cell to initiate the parasitic process. ◆

Letters continued

Appropriate utilization of telemetry beds affects the patients who require their use more than the outcome for the individual stroke patient. Timely referrals to rehabilitation allow patients to begin a functional improvement program that much sooner. It takes the patients off the general medical floors sooner and (theoretically) also decreases their risk for nosocomial infection, aspiration, deep vein thrombosis, and contractures.

All patients' functional status is monitored by healthcare personnel in the Department of Physical Medicine and Rehabilitation. Again, because this monitoring was not directly implemented as a result of the pathway, we did not report on it. The functional improvement measure scores did not change significantly the year before the pathway was implemented compared with the year after the implementation.

I also think that most physicians want to practice good quality care. Information can be relayed to physicians, and we generally adhere to it. The difficulty lies in getting us busy physicians to "hear" the information—and to remember it. Educating physicians requires frequent reminders. With time, change *does* take place. Many physicians still refuse to attend educational meetings; these same physicians' patients have the greatest lengths of stay and their doctors have the poorest utilization. Nevertheless, I am sure that in their minds, these physicians desire to practice good quality care.

The length of stay during our study period remained higher than was our goal because the patients stayed in the hospital while receiving no interventions. In my opinion, this is poor utilization and puts such patients at risk for further problems that can occur with prolonged length of stay. The question then becomes, "Is poor utilization poor care?" ◆

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