The James A Vohs Award

Editorial: The James A Vohs Award for Quality—The Permanente Journal Sixth Annual Special Issue

2003 Vohs Award Winner
12 Initiative to Improve Mammogram Interpretation

Editorial: The David M Lawrence, MD, Chairman’s Patient Safety Award

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5 PERMANENTE ABSTRACTS

24 ANNOUNCEMENTS

28 BOOK REVIEWS

103 CME EVALUATION FORM

Spring 2004/Volume 8 No. 2

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41 Correlative Consult

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Using a brief case profile, this article discusses the rationale and indications for administra-

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Preliminary Review of 21 Monophasic Polio Vaccine (Salk Vaccine). Janet L. B. Shope, MD

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Submitting Artwork: Send us a high-quality color photograph of your art no smaller than 4”x5” and no larger than 8”x10”. Please include a cover letter explaining Kaiser Permanente association, art background, medium and a brief statement about the artwork (description, inspiration, etc). Electronic and e-mail submissions are accepted; 600 dpi resolution is required.

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Share Your Insights

The Institute of Medicine’s report, *Health Professions Education: A Bridge to Quality*, identified five core competencies for all clinical disciplines, including the delivery of care by a multidisciplinary team. It is essential that clinicians learn and share with each other their respective discipline’s research and clinical expertise so that we can continuously improve our ability to work together as a team on behalf of our patients and members.

Nurses have a long tradition of collaboration with physicians and members of the clinical team in the care and management of our members and patients at Kaiser Permanente. In today’s complex health care environment, the smooth functioning of multidisciplinary teams is critical to providing safe, high-quality care.

With this second issue of distribution of *The Permanente Journal* to nurses, I encourage you to do your part to enhance the continuing excellence of the clinical multidisciplinary teams at Kaiser Permanente by taking full advantage of this opportunity to participate in this publication. Read the articles, and think about the application to your daily practice. Share your insights with each other, and consider contributing an article. I welcome your feedback about the value of *The Permanente Journal* in your professional practice. Enjoy, learn, and share.

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**Reference**


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**Circulation Note**

Even though the editors and staff of *The Permanente Journal* know our circulation numbers well, readers may not. With the addition of nurses to the circulation, the journal is now directly sent to 27,000 people. In addition, in 2003, the journal Web site had an average of 47,000 hits per month.
Impaired Adult Worker Performance
Good Day Dr Felitti,
I just wanted to tell you how much I enjoyed the recent article on Impaired Adult Worker Performance (Perm J 2004 Winter;8(1):30-8). I sent out an e-mail to the group I work with here in Baldwin Park to recommend it. It also reminded me of how much I miss your energy and input. I try to march on in family practice talking about the principles you so relentlessly imparted on the HAC staff while I was there.

Julie Marenco, NP
Baldwin Park, CA

Crossword Puzzle
Dear Editor,
I enjoyed the crossword puzzle by Ken Berniker in the last issue (Perm J 2003 Fall;7(4):75). Especially the one about the thoracotomy being a way to a man’s heart!

Thanks,
Brett Nelson

First 50 Years of SCPMG
Dear Mr Fifer,
I enjoyed your article in The Permanente Journal summarizing the First 50 Years of SCPMG (Perm J 2003 Fall;7(4):66-7). I would offer a small correction. The photo of Drs Kay and Garfield playing ping pong was actually taken by Betty Runyen, Dr Garfield’s field nurse) in 1933, when Dr Kay took some time off from LA County to travel the 120 miles or so to Desert Center and visit the hospital built by his friend, Dr Garfield. It was on visits like these, as the two men began to see the potential of prepaid group practice, that they began visualizing a new sort of health care delivery system. I take a special interest in this spot because, after having been “lost” for almost a half-century, I located it and had it declared a State historic site. I also “found” Betty Runyen, who had lost touch with Dr Garfield when he moved up to Grand Coulee Dam. She gave me hundreds of photos of life at the hospital that I have donated to KP.

As a historian who has taken a special interest in the development of the Permanente model as well as the life and impact of Henry Kaiser, I am delighted at the increasing interest being shown in your history by the people who are writing the next chapter of it.

With best wishes,
Steve Gilford
sageprod@aya.yale.edu
Historical Consultant for SCPMG: The First Fifty Years and the writer/publisher of On This Day in Kaiser Permanente History.

A Focus on Preventive Care
Dear Sir,
I read The Permanente Journal: A Focus on Preventive Care, 2004 Winter,(8)1, and I especially liked the following three articles:
1. “Human Embryonic Stem Cells and Type I Diabetes: How far to the Clinic” by Gillian M Beattie and Alberto Hayek (p 11). I had read about more or less successful attempts at pancreas transplants. I had also read about pancreatic islet transplants. But I was impressed by the large number of novel concepts and experiments. It was very interesting and very logically presented. As I teach in a Biomedical Engineering Faculty, it gave me a good research subject to think about.

2. “Childhood Abuse, Household Dysfunction, and Indicators of Impaired Adult Worker Performance” by Robert F Anda, Vladimir I Fleischer, Vincent J Felitti, et al (p 30). I was impressed by the large number (over 9000) of subjects examined and by the conclusions. I had one specific patient today. I simply looked in her papers, saw the environment she came from, and recognized at least four phenomena of adverse childhood experiences: emotional abuse, physical abuse, battered mother, and household substance (alcohol) abuse. She was a housewife and had never been employed. She also was quite difficult to cooperate with. Having read this article made me understand her much better.

3. “PEACE SIGNS: A Sustainable Violence Prevention Collaboration Between Managed Care and School Health Programs” by John Fontanesi, Jill Rybar, Neil Alex, et al (p 67). Although I teach in the University and not in school, I admit I had some students who tried to behave incorrectly. For example, when I entered the classroom one day, there were two new boys hitting a computer as if they played the piano. I disliked it totally because they were destroying the computer. Still, I smiled and made a joke. “Well, it does sound like Mozart, doesn’t it?” We all burst into laughing, and they were eager to listen to whatever else I said, lesson included. So I learned that a nice word can change a student’s mind, and they understood that I would not reject them.

These are the articles I liked best this issue. I am looking forward to reading the Spring issue too.

Sincerely yours,
Roxana CovaI, MD
University of Medicine and Pharmacy, Iasi, ROMANIA

— Reply
Thank you for your delightful letter citing the articles and your reasons, including two stories of application. I’m impressed that you find the journal useful and excited to know that it has value for you.

Regards
Tom Janisse, MD, Editor-In-Chief

From Our Readers …

letters to the editor
The Beloved Community

Dr Janisse,

I think the manuscript, “The Beloved Community: From Civil Rights Dream to Public Health Imperative,” (Perm J 2004 Winter;8(1):58-62) is very interesting! In a perfect world, this would be what we are all searching for—that poverty, hunger, bigotry, and all forms of discrimination and prejudice would vanish; that all peoples would look out for the welfare of everyone else; that it would be human nature to protect everyone else. This is something that may happen, but I cannot see it happening in my lifetime.

I think that love for one’s fellows is a good thing, and most societies have some form of this idea embedded, mainly through religion, but not necessarily. On the other hand, most great or powerful societies tend to reward people/groups who espouse “Manifest Destiny.” Britain, America, Japan, and other powerful nations have all felt it was okay to be brutal in the name of Manifest Destiny. It’s this idea that we have the duty to control other people who are “different” from us that will never allow The Beloved Community idea to occur. In my opinion, we, as Americans, still have this feeling (it’s not limited to America, however). Right now we want to have Arabs think like us. In my opinion, it will not work.

As for the theory that disease follows the gradient of one social hierarchy, I think this is true and false: nothing is absolute, ever. The situation is multifactorial. In America the average lifespan of Native Americans is about 45. There are Native Americans who live into their 80s and 90s, but these people are not necessarily wealthy. Unemployment on most reservations is about 50%-60%. Alcoholism, homicide, and suicide are all high. Stress of life on reservations and the hopeless and helpless feeling most people have is a big factor.

African Americans are another group for whom the gradient theory has some true and false components. For example, during the 60s through the 90s, some African Americans made large gains in income and position in society. However, the overall lifespan of African Americans has actually declined during this same time period. It is interesting to me that the lifespan of African-American males has steadily declined during this time. AIDS was the major factor related to the decline in the lifespan of African Americans. What’s more, the lifespan of African-American physicians also went down significantly during this time period. I think this was multifactorial, however. African-American physicians are usually working in African-American communities where patients are more ill, and this places these physicians under greater stress.

The other leading cause of mortality and morbidity in the African-American community is violence. Gun-caused mortality and morbidity isn’t limited to the African-American community; America has the honor of having the highest rate of morbidity and mortality related to guns than any other industrialized nation.

The stress theory to me has some strengths, but I cannot see it as a pure cause of all that ails America. I feel Japan is a much more stressful society than America. People work six to seven days per week; most work 12 or more hours per day. The living conditions are crowded. Conformity, uniformity, and honor are the rules for Japanese society (actually society is more important than the individual). I think this is close to the Roseto effect of a community the article talked about. Japan has one of the longest lifespans of any industrialized nation. On the other hand, it also has one of the highest suicide rates of any industrialized nation. Japan would fit the picture of a country where one shows love and honor for one’s fellow man, but I’m not sure Japan would fit the perfect picture to be the model for the “Beloved Community.”

I think the “Beloved Community” is the ideal and the goal of what the world should be like. We should take care of our poor, our needy, the weak, and it should be the responsibility of everyone to take part in doing so. Not everyone thinks the same way I do, and, in fact, some people think it’s their destiny to take advantage of those who are weak and in need. The thing is they don’t see what they might be doing as something wrong. They see it as a duty, and, in fact, they feel they are actually helping those same people that I think are being hurt. It’s a matter of culture and perspective. There is no absolute right and there is no absolute wrong. Life is both right and wrong—it’s a contrast. Culture in America is continually changing. There is not just one answer but many different answers. What is right is going to depend on the timing.

Theopolis Williams, MD
Family Practice
Vancouver Medical Offices
Vancouver, WA

Hemochromatosis Update

Dear Vincent,

After reading your most lucid article in the recent Permanente Journal (Hemochromatosis Update, Perm J 2004 Winter;8(1):39-44), I feel comfortable for the first time in my understanding of genetic or hereditary hemochromatosis.

From screening for it, diagnosing it, and treating it (or not treating it), I now know what it is all about.

I was intrigued by your making such good use of blood obtained by phlebotomy. I wish we were doing the same at Sunset.

With great appreciation,
Irving Ackerman
Former Chief of Medicine
Sunset Medical Center, Los Angeles, CA
Abstracts of Articles Authored or Coauthored by Permanente Physicians

From Southern California: Effectiveness of a home-based palliative care program for end-of-life

**CONTEXT:** Despite the widespread recognition of the need for new models of care to better serve patients at the end-of-life, little evidence exists documenting the effectiveness of these models.

**OBJECTIVE:** To evaluate the effectiveness of a palliative program for end-of-life care.

**DESIGN:** A comparison group study was conducted between March 1999 and August 2000 comparing subjects enrolled in a palliative care intervention to those receiving usual care.

**SETTING:** Home Health Department at Kaiser Permanente, TriCentral Service Area.

**SUBJECTS:** During the course of the two-year study, 558 subjects were enrolled. A subgroup of 300 patients who had died during the course of the study was selected for analysis; 161 were enrolled in the Palliative Care Program and 139 in the comparison group.

**INTERVENTION:** The Kaiser Permanente Palliative Care Project is a multidisciplinary care management approach for home-based end-of-life care and treatment. The program is designed to facilitate the transition from acute to palliative care during the last 12 months of life with the goal of improving quality of life through the provision of symptom control and pain relief, emotional and spiritual support, and patient education.

**MAIN OUTCOME MEASURES:** Medical service use and satisfaction with services.

**RESULTS:** Palliative care patients had increased satisfaction with services at 60 days after enrollment and significantly fewer emergency department visits, hospital days, skilled nursing facility days, and physician visits than those in the comparison group. Those enrolled in palliative care averaged a 45% decrease in costs as compared to usual care patients.

**CONCLUSION:** Through integrating palliative care into curative care practices earlier in the disease trajectory, chronically ill patients nearing the end of life report improved satisfaction with care and demonstrate less acute care use resulting in lower costs of care. In addition, patients enrolled in the palliative care program were more likely to die at home than comparison group patients.

From Colorado: Implementing practical interventions to support chronic illness self-management

**BACKGROUND:** Self-management support (SMS) is the area of disease management least often implemented and most challenging to integrate into usual care. This article outlines a model of SMS applicable across different chronic illnesses and health care systems, presents recommendations for assisting health care professionals and practice teams to make changes, and provides tips and lessons learned. Strategies can be applied across a wide range of conditions and settings by health educators, care managers, quality improvement specialists, researchers, program evaluators, and clinician leaders. Successful SMS programs involve changes at multiple levels: patient-clinician interactions, office environment changes; and health system, policy, and environmental supports.

**CLINICAL IMPLICATION:** This article discusses how to achieve patient self-management at each of three levels: patient-clinician interactions, the office environment, and the systems/policy/environmental level. There are established evidence-based self-management principles that work for both chronic illness management and prevention. Specific applications need to be tailored to each clinical setting. The organizations that are most successful in achieving self-management use approaches that are multilevel, patient-centered, proactive, and population-base; plan patient visits and follow-up contacts; create prompts and reminders for both patients and clinicians; and distribute responsibilities for self-management support across all team members. —RG

From the Northwest: Complications in young adults with early-onset type 2 diabetes: losing the relative protection of youth

**OBJECTIVE:** To determine whether adults diagnosed with type 2 diabetes from age 18 to...
44 years more aggressively develop clinical complications after diagnosis than adults diagnosed at <45 years of age.

**RESEARCH DESIGN AND METHODS:** We compared outcomes among 7844 adults in a health maintenance organization who were newly diagnosed with type 2 diabetes between 1996 and 1998. We abstracted clinical data from electronic medical, laboratory, and pharmacy records. To adjust for length of follow-up and sex, we used proportional hazards models to compare incident complication rates through 2001 between onset groups (mean follow-up 3.9 years). To adjust for the increasing prevalence of macrovascular disease with advancing age, onset groups were matched by age and sex to control subjects without diabetes for onset groups. To adjust for the increasing prevalence of macrovascular disease with advancing age, onset groups were matched by age and sex to control subjects without diabetes for onset groups.

**RESULTS:** Adults with early-onset type 2 diabetes were 80% more likely to begin insulin therapy than those with usual-onset type 2 diabetes (hazard ratio [HR] 1.8, 95% CI 1.5-2.0), despite a similar average time to requiring insulin (approximately 2.2 years). Although the combined risk of microvascular complications did not differ overall, microalbuminuria was more likely in early-onset type 2 diabetes than usual-onset type 2 diabetes (HR 1.2, 95% CI 1.1-1.4). The hazard of any macrovascular complication in early-onset type 2 diabetic patients compared with control subjects was twice as high in usual-onset type 2 diabetic patients compared with control subjects (HR 7.9 vs 3.8, respectively). Myocardial infarction (MI) was the most common macrovascular complication, and the hazard of developing an MI in early-onset type 2 diabetic patients was 14-fold higher than in control subjects (HR 14.0, 95% CI 6.2-31.4). In contrast, adults with usual-onset type 2 diabetes had less than four times the risk of developing an MI compared with control subjects (HR 3.7, p < 0.001).

**CONCLUSIONS:** Early-onset type 2 diabetes appears to be a more aggressive disease from a cardiovascular standpoint. Although the absolute rate of cardiovascular disease (CVD) is higher in older adults, young adults with early-onset type 2 diabetes have a much higher risk of CVD relative to age-matched control subjects.

**From the Northwest:**

Screening rarely screened women: time-to-service and 24-month outcomes of tailored interventions


**BACKGROUND:** Managed care organizations and others reaching out to underscreened women seek strategies to encourage mammogram and Pap screening.

**METHODS:** Female HMO members aged 50-69 years and overdue for a mammogram and a Pap test (n = 501) were followed for 24 months after interventions began. An Outreach intervention (tailored letters and motivational telephone interviews), an Inreach intervention (motivational interview delivered in clinics), and a Combined Inreach/Outreach intervention were compared to Usual Care at 24 months. Logistic regression and Cox hazard models examined predictors of obtaining screening services and time-to-service, respectively.

**RESULTS:** Compared with Usual Care, the odds of Outreach women aged 50-64 obtaining a mammogram (OR = 2.06; 95% CI = 1.59-5.29), a Pap test (OR = 1.97; 95% CI = 1.12-3.53), or both (OR = 2.53; 95% CI = 1.40-4.63) remained significantly increased at 24 months. The average time-to-service for Outreach women was reduced by four months. Outreach effects persisted despite intensive, ongoing health plan efforts to improve screening of all women.

**CONCLUSIONS:** This brief, tailored outreach intervention was an effective strategy for encouraging cervical and breast cancer screening among women overdue for both screening services. It also shortened time-to-service, an important benefit for early detection and treatment. Alternative strategies are needed for women who remain unscreened.

**From Northern California:**

Reproductive health counseling at pregnancy testing: a pilot study


**OBJECTIVES:** To pilot brief reproductive health counseling for women obtaining pregnancy testing in a managed-care setting who did not desire pregnancy.

**METHODS:** Women received counseling, access to contraception and a booster call at two weeks. Changes in contraceptive behavior were evaluated.

**RESULTS:** Of 85 women who completed counseling, 58 (68%) completed follow-up. Participants reported that counseling was useful at baseline (94%) and follow-up (83%). The staff found the intervention important (100%) and implementation feasible (100%). Forty-one percent of participants improved their use of contraception (from no use or from less effective use to more effective use). Twenty-nine percent continued highly effective use and 9% recessed from highly effective use. Of 22 participants with risk of sexually transmitted disease, three (14%) began using condoms consistently, while one (5%) continued using condoms consistently.

**CONCLUSIONS:** Counseling at pregnancy testing was well accepted by the staff and participants. Observed behavioral changes suggest that this intervention may be effective in increasing effective use of contraception.

**From the Northwest:**

Older women with fractures: patients falling through the cracks of guideline-recommended osteoporosis screening and treatment


**BACKGROUND:** Many older patients with fractures are not managed in accordance with evidence-based clinical guidelines for osteoporosis. Guidelines recommend that these patients receive treatment for clinically ap-
parent osteoporosis or have bone mineral density measurements followed by treatment when appropriate. This cohort study was conducted to further characterize the gap between guidelines and actual practice with regard to bone mineral density measurement and treatment of older women after a fracture. Our purpose was to aid in the design of more effective future interventions.

**METHODS:** We identified female members of a not-for-profit group-model health maintenance organization who were 50 years of age or older and who had a diagnosis of a new fracture as defined in the study. We used administrative databases and the clinical electronic medical records to obtain data on demographics, diagnoses, drugs dispensed by the pharmacy, and the measurement of bone mineral density.

**RESULTS:** The study population included 3812 women with an average age of 71.3 years. Fewer than 12% of the women had a diagnosis of osteoporosis prior to the index fracture; 10.7% had an increased risk for secondary osteoporosis and 38.8%, for falls because of a diagnosis or medication. It was found that 46.4% of the study population had been managed as specified by clinical guidelines. The patients who had been managed as specified by the guidelines were younger and less likely to have the risk factor of a weight of <127 lb (58 kg), a hip fracture, or a wrist fracture. They were also more likely to be taking steroids on a chronic basis and to have had a vertebral fracture. The percentage of women who had measurement of bone mineral density increased during the study period, from 1.3% in 1998 to 10.2% in 2001. Of the patients receiving treatment for osteoporosis, 73.6% adhered to the treatment regimen.

**CONCLUSIONS:** Adherence to guidelines for evaluation and treatment for osteoporosis after a patient sustained a fracture did not improve between 1998 and 2001 despite the promulgation of evidence-based guidelines. Methods to enhance education and facilitate processes of care will be necessary to reduce this gap. It may be fruitful to target high-risk subgroups for tailored interventions for prevention of refracture.

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**From Northern California:**

**Hot tub use during pregnancy and the risk of miscarriage**


To examine whether hot tub or whirlpool bath use during pregnancy increases the risk of miscarriage, the authors conducted a 1996-1998 population-based prospective cohort study at the Kaiser Permanente Medical Care Program in Oakland, California. Of 2729 eligible women, 1063 completed the interview. Miscarriage before 20 weeks of gestation was ascertained for all participants. Information on hot tub or whirlpool bath use was obtained during an in-person interview conducted early in the pregnancy. A Cox proportional hazards model was used to estimate the hazard ratio after adjustment for potential confounders. Compared with nonuse, use of a hot tub or whirlpool bath after conception was associated with a twofold increased risk of miscarriage (adjusted hazard ratio (aHR) = 2.0, 95% confidence interval: 1.3, 3.1). The risk seemed to increase with increasing frequency of use (aHR = 1.7 for less than once a week, aHR = 2.0 for once a week, and aHR = 2.7 for more than once a week) and with use during early gestation (aHR = 2.3 for initial use within the first four weeks of the last menstrual period and aHR = 1.5 for initial use after four weeks of the last menstrual period). Findings suggest an association between use of a hot tub or whirlpool bath during early pregnancy and the risk of miscarriage.


**Clinical Implication:** For women (1) who are pregnant, (2) who are planning on being pregnant, and (3) who are sexually active, though not “planning” a pregnancy, they should stop using hot tub or Whirlpool bath during first trimester to reduce their risk of miscarriage. However, they may want to consider to stop using hot tub or Whirlpool bath throughout the pregnancy because there have been reports that hyperthermia in pregnancy increases the risk of certain birth defects. Use of regular bath tub did not increase the risk of miscarriage in our study. —DL

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**From Northern California:**

**Nonvitamin, nonmineral supplement use over a 12-month period by adult members of a large health maintenance organization**


**OBJECTIVE:** National survey data show an increase in the prevalence of nonvitamin, nonmineral (NVNM) supplement use among adults over the past ten years. Concern over this trend is based in part on reports of potential drug-supplement interactions. The type and prevalence of supplement use by demographic and behavior characteristics were examined among members of a large group model health plan, including those with selected health conditions.

**DESIGN:** Data on the use of herbal medicines and dietary supplements among survey respondents were analyzed. Questions employed a checklist for six specific NVNM supplements with optional write-ins.

**SUBJECTS/SETTING:** A stratified random sample of 15,985 adult members of a large group model health maintenance organization in northern California, who were respondents to a 1999 general health survey.

**STATISTICAL ANALYSES PERFORMED:** Analyses were conducted with poststratification weighted data to reflect the actual age, gender, and geographic distribution of the adult membership from which the sample was drawn.

**RESULTS:** An estimated 32.7% of adult health plan members used at least one NVNM supplement. The most frequently used herbs were Echinacea (14.7%) and Gingko biloba (10.9%). Use of all NVNM supplements was highest among females, 45 to 64 years of age, whites, college graduates, and among those with selected health conditions.

**APPLICATIONS:** Dietetics professionals need to uniformly screen clients for dietary supplement use and provide accurate information and appropriate referrals to users. Reprinted with permission from the Journal of the American Dietetic Association, 103(11), Schaffer DM, Gordon NP, Jensen CD, Avins AL, Nonvitamin, nonmineral supplement use over a 12-month period by adult members of a large health maintenance organization, p 1500-5, Copyright 2003, with permission from the American Dietetic Association.

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**Nonvitamin, nonmineral supplement use among adults ages 50 years and older by health plan and state**


The use of nonvitamin, nonmineral supplements (NVNM) among adults ages 50 years and older is increasing. Among 15,985 members of a large group model health plan, NVNM supplement use was highest among females, 45 to 64 years of age, whites, college graduates, and among those with selected health conditions.

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Abstracts of Articles Authored or Coauthored by Permanente Physicians

From Southern California:
Restenosis in intervened coronaries with hyperhomocysteinemia (RICH)

BACKGROUND: Controversy exists regarding the contribution made by elevated serum homocysteine levels in raising the risk of restenosis after percutaneous coronary interventions. The objective of this study was to determine whether elevated homocysteine levels increase the risk of restenosis.

METHODS: Two hundred and two consecutive patients undergoing percutaneous coronary intervention with stents on previously nonintervened native coronary arteries were eligible for enrollment in the study. Before the percutaneous coronary intervention, a fasting serum homocysteine level was drawn. Patients were followed-up by their primary cardiologists for recurrence of symptoms. Those patients who had a recurrence of anginal symptoms consistent with clinical restenosis were referred for a repeat angiogram. All other patients were followed-up medically. The homocysteine levels of the patients who had repeat angiography for recurrent symptoms were compared to those who were followed-up medically.

RESULTS: Age, stent length, stent diameter, and homocysteine levels were all associated with an increased risk of restenosis in the univariate analysis. In the multiple logistic regression model, the only variable that remained significant in relation to an increased risk of restenosis was homocysteine. There was a significant difference in the mean homocysteine levels between the restenosis group (13.7 micromol/L) and those without restenosis (9.6 micromol/L; p < .0001). A homocysteine level ≥11.1 micromol/L was identified as the best threshold for an increased risk of restenosis with a sensitivity of 75.0% and specificity of 76.9% (OR 6.5, CI 2.3-18.6; p = .0004).

CONCLUSION: This study demonstrates that elevated homocysteine levels strongly correlate with an increased risk of restenosis. Reprinted from American Heart Journal 146(6), Kojoglanian SA, Jorgensen MB, Wolde-Tsadik G, Burchette RJ, Aharonian VJ, Restenosis in Intervened Coronaries with Hyperhomocysteinemia (RICH), p 1077-81, Copyright 2003, with permission from Elsevier.

From Northern California:
Dietary intake of n-3, n-6 fatty acids and fish: relationship with hostility in young adults—the CARDIA study

BACKGROUND: Hostility has been shown to predict both the development and manifestation of coronary disease. Examining the inter-relation of dietary intake of fish and of polyunsaturated (n-3 and n-6) essential fatty acids with hostility may provide additional insights into the cardioprotective effect of dietary fish and polyunsaturated fatty acids.

OBJECTIVE: To examine the association of dietary n-3, n-6 fatty acids and fish with level of hostility in a sample of 3581 urban white and black young adults.

DESIGN: Cross-sectional observational study as part of an ongoing cohort study. A dietary assessment in 1992-1993 and measurement of hostility and other covariates in 1990-1991 were used in the analysis.

RESULTS: The multivariate odds ratios of scoring in the upper quartile of hostility (adjusting for age, sex, race, field center, educational attainment, marital status, body mass index, smoking, alcohol consumption and physical activity) associated with one standard deviation increase in docosahexaenoic acid (DHA, 22:6) intake was 0.90 (95% CI = 0.82-0.98; p = 0.02). Consumption of any fish rich in n-3 fatty acids, compared to no consumption, was also independently associated with lower odds of high hostility (OR = 0.82; 95% CI = 0.69-0.97; p = 0.02).

CONCLUSIONS: These results suggest that high dietary intake of DHA and consumption of fish rich in n-3 fatty acids may be related to lower likelihood of high hostility in young adulthood. The association between dietary n-3 fatty acids and hostile personality merits further research.

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To Make A Contribution

The circumstances of your life have uniquely qualified you to make a contribution. And if you don’t make that contribution, nobody else can make it.

—Rabbi Harold S Kushner, b 1935, Rabbi Laureate of Temple Israel in Natick, MA, author of When Bad Things Happen to Good People
Dr Barber is a retired internist from the KP Harbor City Medical Center in Southern California. He now works per diem at the KP clinic in Gardena, CA.

More of Dr Barber's art can be found on the cover.
Considering the difficulties and inevitable discomfort associated with change, we who practice Permanente Medicine can feel proud of our acceptance of perpetual evolution in our medical practice. Many organizations have foundered for failure to deal with this need. We are fortunate that emphasis upon continual improvements has always been a primary concern of the leaders of the Kaiser Permanente (KP) Medical Care Program. Adaptation to new knowledge and technologies improves the quality of our patients’ care and ensures our survival in the competitive health care marketplace. Perhaps our flexibility is partially a result of the fact that our system was started by pioneers who made a huge revolutionary change in the established medical system. In any case, our acknowledged long-term success is a tribute to the adoption of the philosophy that we need to constantly evaluate and improve what we do.

James A Vohs was a creative champion of innovation and improvement in Permanente Medicine. Upon his retirement from 17 years as President, CEO, and Chairman of the Boards of Kaiser Foundation Health Plan, Inc, and of Kaiser Foundation Hospitals, Inc, the James A Vohs Award for Quality was established. The intent was to recognize and honor projects that advance the quality of care, showcase innovative techniques, produce transferable knowledge, and underscore the value of multidisciplinary teamwork. Annually, each KP Division is invited to nominate one or two projects, either new ones or major improvements in existing ones. The award is presented for the project best representing an established effort to improve quality through objectively documented and institutionalized changes in direct patient care. The selection criteria include demonstration of measurable improvement in care and potential for transfer to other locations as a “successful practice.” Thus, the benefits ultimately extend to large numbers of KP members nationally and to the general community and the entire health care industry.

We present in this issue the 2004 Vohs Award winner from the KP Colorado Region entitled “Mammography Interpretation Improvement Initiative.” Started in 1996 by the radiology leadership team composed of Kaiser Foundation Health Plan and Permanente Medical Group personnel, the objective was to minimize variability and inaccurate interpretation of mammograms. Reasons for variation in interpretation, the potential for improvement, and innovations to affect improvement were thoroughly and systematically assessed. The five-year results are impressive, including substantial improvements in sensitivity of diagnosis to levels not achieved elsewhere and increased detection of Stage 0 or Stage 1 lesions. The American Cancer Society statement in the June 28, 2002 New York Times sums it up: “Every mammography program in the country should be doing something like this.”

Publication of the Vohs winners perfectly fits the stated mission of The Permanente Journal “to promote the delivery of superior health care through the principles and benefits of Permanente Medicine.” This year’s winner represents a triumph of Permanente Medicine. We have now published 16 Vohs projects over a six-year period, representing many Kaiser Permanente Regions and most major medical specialties. The topics preponderantly involve: 1) preventive practices (pediatric practice, immunizations, breast cancer), 2) management of chronic illness (asthma, diabetes, heart disease, cancer, COPD, sickle cell disease), 3) computerization of medical data and 4) drug utilization. A number have already rapidly spread to use by other regions.

We remind the reader that, while the process for nomination has some local variation, each KP Division has contact liaisons easily located through its regional quality representative. Nominations need approval by that KP Division’s President and Medical Director, and applications are due September 1st each year. There is no monetary gift with the James A Vohs Quality Improvement Award, but there is much recognition. The winning KP Division receives an engraved award, and project team members receive awards. Winners and runners-up are invited to present their projects at a reception hosted by the KP National Boards of Directors, Division Presidents, and...
editorial comments

other Program Officers. The awardees also receive publicity through the Quality Notes newsletter and through local, state, and national press releases. Of course, the “real” award is the knowledge of having done good work which made a real difference in people’s lives.

A Vohs Award Selection Committee includes KP National Board of Directors members, a Vohs family member, Chairman Bob Crane, Program Office quality representatives, a Permanente Federation representative, and two nonvoting Program Office quality representatives. This Committee announces its selection at the December Board of Directors meeting and team members are contacted by phone within the next day or two. The recognition ceremony takes place at the March Board of Directors meeting.

The possibilities for projects are limited only by the imaginations of our health professionals. Undoubtedly, many qualifying programs have not been submitted. Part of our purpose in publishing these projects is the hope that they will serve as models to motivate others to present projects for consideration. The process is an opportunity to share with 11,000 KP physicians and the general health care community your ideas about improving care of illness and providing health information.

The possibilities for projects are limited only by the imaginations of our health professionals.

Striving To Prove

We are striving to prove: 1) that high quality medical and hospital services can be rendered to the people at a cost they can afford;

2) that this can be done to the benefit of all concerned—the people, the physicians, and the hospitals; last and not least that it can be done by private enterprise without necessity of government intervention. There is nothing sacred or secret in the idea. This cannot help but become more evident in the coming years.


This “Moment in History” quote collected by Steve Gilford, KP Historian
Introduction

Mammography quality is a significant issue of national concern. The Mammography Quality Standards Act (MQSA) extends regulation to an unprecedented level of detail in the practice of medicine; however, the Act pertains to the technical quality of mammography and is largely silent on the critical issue of the radiologist’s proficiency in interpreting examination results.

The reason that no measure of radiologist proficiency is required may be partly because radiologists often do not know whether a patient whose mammogram they interpreted received a diagnosis of cancer months or years later or lived a long, cancer-free life. Kaiser Permanente (KP), with its well-established databases of patient information, is unique in its ability to monitor and track patient outcome.

Of 370,000 members in the KP Colorado Region, approximately 101,000 are women who are eligible for mammography. For these women, breast cancer is a leading cause of cancer-related deaths. During the past five years, KP Colorado has averaged more than 80% penetration for screening mammography by Health Employer Data Information Set (HEDIS) criteria. However, internal quality audits in late 1995 indicated that breast cancer detectable on mammograms was sometimes being missed.

In 1996, KP Colorado began to implement a multi-faceted initiative to reduce variation and improve accuracy in the interpretation of mammograms. The initiative was conceived and sustained by the radiology leadership team, including staff from Health Plan and medical groups, with extensive sponsorship from Kaiser Foundation Health Plan and Operations. The integrity of vision among top management and the radiology department informed an organizational team spirit that fueled this initiative from its inception. The initiative team members are listed in Table 1.

The project consisted of organizational redesign, quality improvement, and performance management and reflected many innovations in health care delivery, patient safety, continuous quality improvement, and development of subspecialty practice in radiology.

The objective of this initiative was to maximize the number of cancerous lesions detected at an early, curable stage by achieving industry-leading performance in mammographic diagnosis of breast cancer. To achieve this objective, we investigated three issues: reasons for differing levels of performance among radiologists interpreting mammograms; the potential for improvement and barriers to realizing this potential; and innovations that result in sustained improvement in performance.

Initiative to Improve Mammogram Interpretation

This initiative consisted of a series of fundamental changes in the radiology department. These changes included instituting a comprehensive quality assessment program, creating a centralized facility for reading mammograms, and establishing mammography interpretation as a radiology subspecialty.

Quality Assessment Program Measures

On January 1, 1996, the comprehensive quality assessment program for mammogram interpretation was established. Multiple quality measures were—and continue to be—continuously monitored, and data were compared with published benchmarks and with goals of group performance and individual variation as defined early in the project by initiative team members (Table 2). Radiologists received feedback on group results and on their individual results. Performance gaps were analyzed, specific interventions were applied when necessary, and results of the interventions were...
measured. Where persistent gaps existed, additional improvement activities were instituted.

All of the data pertaining to performance were accumulated from raw data derived from the KP Colorado Tumor Registry, from reports of mammogram results (supplemented by chart review), and from Radiology Information System extracts, which were supplemented by review of handwritten records. Kim Adcock, MD, compiled data on sensitivity and stage at diagnosis; and Richard Batts, MD, compiled data on other mammographic indicators. Data were entered into one primary database. The primary database also contained the records of 3742 patients who received a diagnosis of breast cancer from among approximately 400,000 patients who had mammography at KP Colorado from 1993 through 2002. For each case of breast cancer, patient demographics and the stage, nodal status, mammographic diagnosis, and date of diagnosis were recorded. Clearly distinct synchronous lesions were recorded separately. The dataset that was used in analyses included records of all cases of breast cancer diagnosed in KP Colorado from 1993 through 2002.

Our quality assessment analysis focused on the contribution of radiologist proficiency in interpreting mammograms to the overall effectiveness of using mammography for screening. To better assess the radiologists’ contribution in isolation from potential confounders, we first evaluated the influence of patient factors (such as overall penetration of screening, screening interval, and patient age) and technical factors (such as quality of mammography at different facilities) and found little or no influence from these factors. The mammography penetration rate (by HEDIS criteria) varied between 80% and 81% for commercial members and between 81% and 83% for Medicare enrollees, and the proportion of Medicare members in the patient population was stable. A moderate trend was seen during the project for patients to elect earlier screening and to have annual instead of biannual mammography; however, this group of patients constituted a small proportion of overall mammography volume and had a negligible influence on the aggregate performance data. Moreover, radiologist proficiency will appear worse when younger women have mammography more frequently, because this age group has increased breast density, lower prevalence of disease, and more aggressive tumors (and thus more interval cancers). Technical performance was consistent, as assessed by the MQSA inspectors, and no major deficiencies were detected at any mammography facilities throughout the project period.

We defined and held constant throughout the reporting period the criteria for positives and negatives used to calculate sensitivity and positive predictive value.

### Table 2. Quality measures used in Initiative to Improve Mammogram Interpretation

<table>
<thead>
<tr>
<th>Quality measure</th>
<th>Goal</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of cancers detected at stage 0 or 1</td>
<td>80% in 1998</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>85% by 2003</td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>80%</td>
<td>73%</td>
</tr>
<tr>
<td>Cancers diagnosed per 1000 mammograms</td>
<td>&gt;6</td>
<td>6</td>
</tr>
<tr>
<td>Diagnosis of new, probably benign lesion</td>
<td>7% in 1998</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>4% by 2003</td>
<td></td>
</tr>
<tr>
<td>Recall rate for screening mammograms</td>
<td>≤7%*</td>
<td>8.3%</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td>25-40%*</td>
<td>23-53+*</td>
</tr>
<tr>
<td>Annual number of mammograms read per radiologist</td>
<td>&gt;4000</td>
<td>480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3600</td>
</tr>
<tr>
<td>Cost per mammogram per relative value unit</td>
<td>≤Medicare rate</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>120-160%+</td>
</tr>
<tr>
<td>Radiologist satisfaction</td>
<td>&gt;90%</td>
<td>89.25%</td>
</tr>
</tbody>
</table>

* Measures of individual variation are applied. Generally, interventions are conducted when variation exceeds 2 SD.
* The 2003 Medicare reimbursement rate, applying the KP Colorado geographic practice cost index (GCPI), is $36.42.
* Prevailing community commercial reimbursement rate, per KP Colorado External Medical Services Department.
* As an average of the four indicators of overall physician satisfaction assessed in the Colorado Permanente Medical Group physician satisfaction survey.
Centralized Facility

In 1998, the radiology department consolidated multiple medical office practices into a single central reading facility and instituted standardized practices with respect to every facet of interpreting mammograms.

Radiologist Subspecialization

Before 1998, each of the 21 radiologists in the region interpreted mammograms; some radiologists interpreted as few as 40 mammograms per month, the minimum required by the MQSA. During 1998, radiologists who chose to specialize in interpreting mammograms used the centralized facility, where they had access to specialized training, convenient consultation with other radiologists expert at reading mammograms, and exposure to a high volume of mammograms.

Also in 1998, we established mandatory, three-times-per-year mammogram interpretation self-assessment exercises for the subspecialists, exercises that challenge the radiologists to continually assess and improve their mammogram interpretation skills. For each exercise, the department’s clinical mammography specialist (Sheila Duvall), with input from one of the mammogram subspecialist radiologists on rotating assignment, selected mammograms considered within normal limits and mammograms of patients whose breast cancer had been confirmed by histopathologic testing. Typically, the selected mammograms from cancer cases had radiographically subtle changes and included a variety of findings, such as microcalcification, asymmetry, or architectural distortion. Each exercise consisted of three rounds of mammogram interpretation. During the first round, mammograms that had been taken one to two years before cancer was diagnosed were mounted on an x-ray alternator and were randomly mixed with normal mammograms. Each radiologist completed a written assessment and specified the type and location of suspicious findings, if any. The second round consisted of comparing of a patient’s most recent mammogram with that of one year earlier; again, normal and confirmed cancer cases were randomly intermixed. For the third round, the radiologists received the diagnosis for each case and their own written first- and second-round assessments. Periodically, the mammography clinical specialist returned to each radiologist a summary of his or her performance compared with the group performance data. Because this process was oriented toward self-assessment and learning, little emphasis was placed on applying this information to individual performance management. For example, the information was not used in the radiologist’s annual performance appraisal, because evidence shows that test case series do not predict performance in the clinical setting.

Each set of cases assessed was certified for 2.5 hours of American Medical Association category 1 continuing medical education credit, and the exercise was available to radiologists from local private practice groups, who participated intermittently.

Results

Earlier-Stage Breast Cancer Detection

The proportion of patients who will attain five-year disease-free status declines by approximately 40% after breast cancer has reached late stage. Therefore, the ultimate goal of screening mammography is detection of early stage disease, and therefore, this quality measure of radiologist performance is of paramount importance.

Early-stage cancer detection was measured as the proportion of tumors that were detected while at stage 0 or 1. This measure is not solely associated with the radiologist’s interpretive skill: Changing patterns of population penetration of screening and of clinician proficiency in breast examination could profoundly influence early-detection data. However, these potential confounders were stable during this project; therefore, these data specifically measured change in radiologist proficiency. The baseline performance of the group exceeded published standards through 1997 (Figure 1). With the completion of mammography specialization by 1998, however, the group achieved sustained early-stage cancer detection level of nearly 90%, a substantial improvement that exceeded published benchmark values by 10%.
Increased Sensitivity of Mammography

Sensitivity is the number of true positive diagnoses divided by the total number of patients with breast cancer. Sensitivity values vary with data definitions and conventions, and no uniform method for calculating mammography sensitivity is currently in use across the industry. The published details on conventions used in the New Hampshire trial\(^1\) are virtually identical to those we used at KP Colorado; therefore, the New Hampshire results provided excellent benchmarks. Performance data from KP Colorado was statistically indistinguishable from the broad, community-based New Hampshire data until specialization and self-learning were implemented in 1998 (Figure 2). A statistically significant, durable improvement then occurred—resulting in sensitivity levels not achieved elsewhere—and represented the effects of our performance management interventions.

Controlled Variation in Cancer Detection Rate

Detection rate is calculated as the number of cases of cancers detected per 1000 mammograms read. The relatively high group mean detection rate, which ranged from 6.3 in 2000 to 7.5 in 2002, is partially attributable to the combination of diagnostic and screening studies in the data (Figure 3). Individual radiologist performance is not statistically different across the group. The decrease in the spread of the standard deviation (SD) indicates a trend toward controlled interobserver variation.

Normalized Rate of Diagnosing New, Probably Benign Lesions

This locally developed indicator is calculated as the proportion of mammograms a radiologist interprets as showing a new lesion (ie, no earlier mammogram with abnormal result), that is probably benign; this indicator is an early warning sign of vacillating diagnostic criteria. An intervention is conducted when a radiologist deviates significantly from group performance. For example, in early 2002, radiologist “B” diagnosed new, probably benign lesions too frequently, so we instituted a requirement that this radiologist secure a second opinion on any case for which this diagnosis was contemplated. Radiologist B’s rate has normalized over time (Figure 4). The average rate of diagnosing new, probably benign lesions declined as did the variation in rate among radiologists.

Normalized Callback Rate

Patients are commonly recalled for additional views when the screening mammogram result is inconclusive or shows findings potentially indicative of cancer. Such callbacks produce great patient anxiety, consume limited resources, and expose the patient to additional radiation. Evidence generally shows that callback rates above 7% are not justified by improved cancer detection rates;\(^{11}\) however, the New Hampshire\(^1\) experience showed a rate of 8.3% across multiple practices. In KP
Colorado, both group and individual performance are monitored relative to a goal of 7% (Figure 5). When a radiologist exceeds two SD for any quarter, s/he must gain the concurrence of another physician for any proposed recall. After using this simple intervention, we saw rapid normalization of rates in every case.

**Normalized Positive Predictive Value**

The positive predictive value (PPV) is the proportion of patients for whom the radiologist recommends biopsy who then receive a confirmed diagnosis of cancer. In addition to the rate of diagnosing new, probably benign lesions and the callback rate, PPV is an important measure which tracks consistency of the physician’s diagnostic criteria. High PPVs indicate an overly stringent threshold for biopsy and lead to decreased sensitivity for cancer. Low PPV subjects too many patients to the anxiety and discomfort of a breast biopsy. There is no generally accepted range of “correct” PPV: Review of the literature reveals a wide range of reported values. Careful, radiologist-specific analysis of PPVs in the context of the other indicators is necessary to understand whether the radiologist should adjust his or her diagnostic criteria. Feedback of data has effectively normalized individual radiologists’ performance (Figure 6).

**Radiologist Subspecialization and High Satisfaction**

By the end of 1998, the radiologists had specialized, limiting the interpretation of mammograms to a subgroup with proven high performance, and read, on average, 6000 to 7000 studies annually. Throughout the project, the range of mammograms read was 4000 to 14,000 mammograms per radiologist per year and the group average was 8000 mammograms per year by 2002. The number of mammograms read by radiologists comfortably exceeded minimums set by the MQSA, but at the upper levels remained within community standards for mammography specialists.

Although the quality improvement activities concentrated on systems improvement and self-learning, certain intractable performance issues were encountered which necessitated withdrawal of privileges for four radiologists over eight years.

Radiologist satisfaction averaged 91.5% for the overall measures included on the Colorado Permanente Medical Group (CPMG) survey. In anonymous response to the question: “If I had the opportunity to choose again, I would join CPMG,” all 15 of the respondents (of 16 radiologists) agreed or strongly agreed. Survey responses from mammography subspecialists could not be separated from those of other radiologists.

**Decreased Costs**

The net cost of $40,000 per year for this project was calculated by using payroll costs of the following personnel (number in parenthesis is proportion of full-time equivalent [FTE]): radiologist (0.1 FTE), clinical mammography specialist (0.1 FTE), and administrative assistant (0.05 FTE). Nonpayroll costs were negligible.

Relative value unit costs are assigned separately to the professional and technical components of all gov-
government and most commercial service contracts. During our study period, the cost of the professional component relative value unit for each mammogram at KP Colorado declined by 45% and is now approximately $28, or 77% of the Medicare benchmark. In addition, the improved process efficiency of mammogram interpretation generated net savings of more than $3 million during the past seven years.

Discussion

This project builds on the foundation of two unique characteristics of KP—excellent patient information and a performance culture—to produce results that surpassed benchmarks for preventing breast cancer deaths. By implementing a multifaceted initiative to improve interpretation of mammograms, we substantially increased the sensitivity of screening mammography as we diagnosed more cases of cancers at earlier stages without increasing the proportion of callbacks. Simultaneously, we decreased the professional component cost per mammogram. Radiologist satisfaction remains high.

Biostatistician Dr Constantine Gatsonis of Brown University and Dr Robert Smith of the American Cancer Society reviewed the results of the indicators of mammographic sensitivity and stage of cancer at detection at the request of The New York Times. They independently concluded that the increase in sensitivity for cancer detection and the higher proportion of early stage breast cancer represented statistically significant changes.

Results of this program have been described in the popular press:

“The Colorado team] is missing one-third fewer [breast] cancers and has achieved what experts say is nearly as high a level of accuracy as mammography can offer.”

“Every mammography program in the country should be doing something like this.”

“...the Kaiser mammography group has gone perhaps as far as anyone in creating a statistical system for holding doctors accountable for their work.”

“Everybody would like to do this if they could. It is a wonderful learning experience.”

“Even at the nation’s leading cancer centers, doctors say they cannot do what the [Colorado team] has done.”

To the best of our knowledge, this project was unique in its rigorous assessment of radiologist function in breast cancer detection and in applying quality improvement and performance management techniques to improve cancer detection. The project also resulted in excellent levels of detecting early-stage breast cancer.

Acknowledgment

Dave St Pierre, MHROD, consulted with the author on organization of the Vohs Award application content.

References

**Group Practice**

In group practice, there is built-in quality control in the careful choice of doctors, and in the sharing of patients and knowledge. In addition, in our group, each service has a chief of service and a nucleus of senior doctors who work with other clinicians and share their patients' medical problems.

—Ray Kay, founding Medical Director of the Southern California Medical Group.

This “Moment in History” quote collected by Steve Gilford, KP Historian.
The David M Lawrence, MD, Chairman’s Patient Safety Award

Dr Oliver Wendell Holmes (1809-1894) famously and cynically commented a century and a half ago “… if the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes ….” He was probably substantially correct; most medical therapies of his day were likely to do harm. Fortunately, we have come a long way. The great physician/poet/philosopher could not have imagined the highly effective array of drugs, procedures, and preventive measures now available. However, the technologically complex nature of much modern therapy exposes patients to all sorts of potential injury. A stunning technical achievement can be nullified by an error, well exemplified by the widely publicized recent death in a heart-lung transplant recipient due to a blood transfusion mismatch. The rash of headlines about an “epidemic” of thousands of deaths due to medical errors may be exaggerated, but mistakes are always a risk. The Hippocratic-Galenic admonition applies as strongly as ever.

During his 11 years as Chairman and CEO of Kaiser Foundation Health Plan, Inc, and Kaiser Foundation Hospitals, David M Lawrence, MD, challenged Kaiser Permanente (KP) and the entire health care industry to pursue patient safety as an integral component of high-quality care. On the occasion of his retirement, the Chairman’s Patient Safety Award was established by the Board of Directors to recognize and honor projects that advance the quality of care by improving the safety of care. The goals are to: 1) create a culture of safety, 2) develop and standardize successful patient safety measures in KP facilities, and 3) define and implement an innovative and transferable regional intervention in patient safety.

In this issue, we publish the first (2003) David M Lawrence award winner. The award was given to the Southern California Orange County Preoperative Briefing Project. Designed by surgeons, operating room nurses, MD and RN anesthetists, scrub technicians, and administrative support personnel, the objective was to improve patient safety before and during the operating room procedure. The techniques involved were attempts to create a climate of improved communication, collaboration, teamwork, and situational awareness. Measurable results include elimination of wrong-site surgeries, a 19% increase in employee satisfaction, a 16% decrease in nurse turnover, and an increase from “good” to “outstanding” in the perception of safety climate in the operating room.

The Criteria and Guidelines state “Projects nominated for the Chairman’s Patient Safety Award should be evidence-based or experience-based and address significant patient safety issues through substantial, measurable, and transferable changes that positively impact the provision of safe care. Processes or interventions developed through the project may represent innovations related to the patient as a partner in safe care, clinical practices, support systems, safety culture, health care team performance, or the environment of care.” The criteria further specify that award selection will have a bias toward projects that demonstrate a change in outcomes and that preference will favor projects involving members from various disciplines (Health Plan/Hospitals, Medical Group, and Labor). It is desired that projects should be capable of replication interregionally, with a bias toward solutions that are practical, relevant, and cost-effective. It is expected that patient safety issues of considerable scope and magnitude will be addressed with substantial potential impact on the frequency and/or severity of harm.

After a compressed process in 2003, there are to be two annual awards, one to a region with a new project and the second to a region that most...
effectively replicates the success of the prior year’s winner. There will be a call for abstracts in September of each year, and the announcement of the regions selected to submit full papers will occur during the December Award ceremony. The regional nomination should be signed by the KP Regional President and Executive Medical Director and submitted to the National KP Program Offices no later than July first. Regions will then have six months to submit full papers. Winners will be selected by the Board’s Patient Safety Award Committee during its September meeting, and representatives from all KP Regions will be invited to attend the annual Award Dinner during the Board’s December meeting.

There is no monetary reward, but substantial recognition. A limited edition of a blue and white plate with clasped hands etched in gold will be the perpetual trophy. Symbolizing partnership with the patient and commitment to provide trusted, safe care, it will be on permanent display in the Program Offices. Each year, a smaller version of the plate will be presented to the winning region, and individual awards are provided to team members. The winning project will be announced at the Board of Directors’ annual dinner in March.

The winning project will be featured on the Patient Safety Web site, in the Program’s Patient Safety Newsletter (STEPS), and on other appropriate programwide publications and venues.

Harmful treatment is now likely to be a more subtle matter due, for example, to failure to recognize individual risk/benefit aspects related to age/sex/ethnic disparities, cultural differences, or interactions with other therapy. It could be argued that avoidance of all these problems properly belongs to the concept of “patient safety” and that optimal patient safety is substantially synonymous with optimal medical care. In any case, it is gratifying that the culture of Permanente Medicine recognizes so strongly the importance of patient safety. Appropriate are some more upbeat words from Dr Holmes’ son, Oliver Wendell Holmes, Jr: “The great thing in this world is not so much where we stand as in what direction we are going.”

Service To Others

The best way to find yourself is to lose yourself in the service to others.

—Mohandas Karamchand Gandhi, 1869-1948, Indian spiritual and political leader, peace activist, and humanitarian
2003 David M Lawrence, MD, Chairman’s Patient Safety Award Winner

Preoperative Safety Briefing Project

Abstract

Context: Increased media attention on surgical procedures that were performed on the wrong anatomic site or wrong patient has prompted the health care industry to identify and address human factors that lead to medical errors.

Objective: To increase patient safety in the perioperative setting, our objective was to create a climate of improved communication, collaboration, teamwork, and situational awareness while the surgical team reviewed pertinent information about the patient and the pending procedure.

Methods: A team of doctors, nurses, and technicians used human factors principles to develop the Preoperative Safety Briefing for use by surgical teams, a briefing similar to the preflight checklist used by the airline industry. A six-month pilot of the briefing began in the Kaiser Permanente (KP) Anaheim Medical Center in February 2002. Four indicators of safety culture were used to measure success of the pilot: occurrence of wrong-site/wrong procedures, attitudinal survey data, near-miss reports, and nursing personnel turnover data.

Results: Wrong-site surgeries decreased from 3 to 0 (300%) per year; employee satisfaction increased 19%; nursing personnel turnover decreased 16%; and perception of the safety climate in the operating room improved from “good” to “outstanding.” Operating suite personnel perception of teamwork quality improved substantially. Operating suite personnel perception of patient safety as a priority, of personnel communication, of their taking responsibility for patient safety, of nurse input being well received, of overall morale, and of medical errors being handled appropriately also improved substantially.

Conclusions: Team members who work together and communicate well can quickly detect and more easily avoid errors. The Preoperative Safety Briefing is now standard in many operating suites in the KP Orange County Service Area. The concepts and design of this project are transferable, and similar projects are underway in the Departments of Radiology and of Labor and Delivery at KP Anaheim Medical Center.

Introduction

Our patients and their families reasonably expect us to maintain patient safety in the medical environment. Until recently, however, this critical component of medical care did not receive the attention it deserves. Against a background of increased mass media attention to hospital errors, such as performing wrong procedures or performing procedures on the wrong anatomic site or wrong patient as reported in the Institute of Medicine’s 1999 report, “To Err is Human,” and in Lucien Leape’s landmark article, “Error in Medicine,” the medical profession has finally realized that safety is an integral part of the health care that we deliver. These trends, coupled with three wrong-site surgeries and several near misses in the previous year, prompted the Kaiser Permanente (KP) Orange County Service Area (OCSA) to embrace a fundamental cultural change that emphasized safety as part of clinical quality standards of defining the care experience for our health care providers and patients.

Other industries, most notably the aviation industry, have long known the importance of human factors in the etiology of errors and have sought to identify and address human factors that result in errors. KP OCSA already followed several patient safety policies and procedures in the surgical suite, such as use of the Patient Procedure Site Marking Verification Form, to meet Joint Commission on Accreditation of Healthcare Organizations (JCAHO) regulations. However, the Safety, Human Factors, and Preoperative Safety Briefing project was intended to supplement and to add another dimension to patient safety practices by creating a culture whereby team members are formally identified and create a shared mental model by focusing on the patient minutes before the surgical procedure. The project was designed and implemented by a team consisting of surgeons, operating room nurses, anesthesiologists, nurse anesthetists, scrub technicians, inpatient nurses, anesthesiologists, and quality coordinators, risk managers, and administrators (Table 1).

According to the JCAHO, breakdown in communication is the primary cause of serious sentinel events in the healthcare setting ...

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James DeFontes, MD, (right), serves as the Physician Director of Surgical Services in the Orange County, CA MSA and as the Regional Coordinating Chief of Anesthesia for SCPMG. He is an Anesthesiologist with a Surgical Critical Care Fellowship. He has been with KP since 1984. E-mail: james.defontes@kp.org.

Stephanie Surbida, MPH, (not pictured) serves as a Project Manager to Business Administrator—Finance, Systems, & Consulting for SCPMG. She joined KP in 2001 as an Administrative Fellow. E-mail: stephanie.k.surbida@kp.org.
Clinical contributions

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Marc Vanefsky, MD, Chief of Neurosurgery, Regional
Larissa Tan, MD, Chief of Surgery, Assistant to Area
Stephanie Surbida, MPH, Project
Steve Strong, OR Certified Surgical Technologist
Sheila Smith, RN, MHA, CNOR, Perioperative Services
Willie Miranda, RN, Orthopedics and Podiatry Administrator
Michael Messersmith, RN, OR Nurse
Edward Marthaler, CRNA, Anesthesia
James Lau, MD, Orthopedics
Ronald Kohorn, MD, Obstetrics & Gynecology
Debra Innis, MA, Senior Research Analyst for Practice Management, Quality
Janice Bouma, RN, MSN, PhN, RNFA, OR Nurse
James Carlin, MD, Assistant Chief of Anesthesia
Lisa Chen, PhD, Senior Research Analyst for Practice Enhancement for Physicians/Quality Management
Gerard Corros, RN, OR Charge Nurse
Susan Duffy, RN, BS, Quality Management Coordinator,
Surgical Services
Lynee M Fuller, BSHA, Assistant Project Manager,
Perioperative Services
Suzanne Graham, California Regions, Patient Safety Practice Leader
Patricia Green, RN, OR Nurse Educator
Georgina Hayman, RN, OR Charge Nurse
Jeff Hunter, Assistant Medical Center Administrator,
Surgical Service Line
Debra Innis, MA, Senior Research Analyst for Practice Enhancement for Physicians/Quality Management
Ronald Kohorn, MD, Obstetrics & Gynecology
James Lau, MD, Orthopedics
Edward Marthaler, CRNA, Anesthesia
Michael Messersmith, RN, OR Nurse
Willie Miranda, RN, Orthopedics and Podiatry Administrator
Mark Monroe, RN, MS, CSP, CHEM, National Environmental Health & Safety Project Manager
Sheila Smith, RN, MHA, CNOR, Perioperative Services Administrator
Steve Strong, OR Certified Surgical Technologist
Stephanie Surbida, MPH, Project Manager/Administrative Fellow
Larissa Tan, MD, Chief of Surgery, Assistant to Area Associate Medical Director
Marc Vanefsky, MD, Chief of Neurosurgery, Regional Coordinating Chief of Neurosurgery

Table 1. Preoperative Safety Briefing Team members

<table>
<thead>
<tr>
<th>Team leadership:</th>
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<tbody>
<tr>
<td>James DeFontes, MD, Chief of Anesthesia, Regional Coordinating Chief of Anesthesia Physicians, Director of Surgical Services</td>
</tr>
<tr>
<td>Mark Gow, MD, General Surgery, Physician Director of Patient Safety</td>
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<tr>
<td>Kathy Dower, RN, MHA, Quality Management Leader</td>
</tr>
<tr>
<td>Gabrielle Cioffi-Kogod, RN, MPH, Risk Manager, Orange County Service Area</td>
</tr>
<tr>
<td>Team members:</td>
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<tr>
<td>David Bohner, CRNA, Anesthesia Administrator</td>
</tr>
<tr>
<td>Doug Bonacum, MBA, CSP, Vice President, Safety Management, Quality</td>
</tr>
<tr>
<td>Janice Bouma, RN, MSN, PhN, RNFA, OR Nurse</td>
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<tr>
<td>James Carlin, MD, Assistant Chief of Anesthesia</td>
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events in the healthcare setting; 75% of these events result in patient death. On the basis of this and other factors analysis and design, a Preoperative Safety Briefing for surgical teams in the KP OCMA was developed: a document and procedure very similar to the preflight checklist used by pilots. The purpose of the briefing is to maximize the ability of health care providers to effectively identify and manage human error and other threats to patient safety. Important elements of the project design included creation of a climate of improved communication, collaboration, teamwork, and situational awareness in the perioperative setting.

The Safety, Human Factors, and Preoperative Safety Briefing project focused on these five specific objectives:

- To build awareness of safety culture and identify safety needs.
- To build support by enhancing staff knowledge of the existing “operating suite culture” and potential barriers to safety inherent in that environment.
- To develop a Preoperative Safety Briefing model to enhance effective communication and anticipation/management of threats and errors.
- To educate all stakeholders and implement the Preoperative Safety Briefing model in the operating suite.
- To evaluate the model’s success using prepilot and postpilot attitudinal surveys.

Developing the Preoperative Safety Briefing

The project centered around the Preoperative Safety Briefing, a brief activity in which the members of the surgical team discuss the background of the case, assess threats and risks, and offer any other relevant information. A one-page document reminds team members of key relevant questions regarding patient safety (Figure 1). The briefing is required after induction and before a surgical procedure. Briefings are also encouraged at handoffs and other special situations (eg, training new team members). Although simple, the briefing design encourages and requires collaboration and consensus from each member of the perioperative team. In addition, the check-in procedure fosters a more collegial atmosphere, which encourages monitoring, facilitates cross-checking, and empowers all team members to be proactive about patient safety in the perioperative setting.

The Human Factors Steering Committee presented the original concept to key members of the operating staff, anesthesia department, and surgical services at the KP Anaheim Medical Center in October 2001. Components of the Preoperative Safety Briefing were designed by a team consisting of operating room and anesthesia staff and surgeons from different disciplines, who then met monthly to develop and later to refine the design used in training their staff and colleagues until the pilot started in February 2002. Quantitative results of monthly surveys during the pilot helped the team to improve the design, identify other safety supplements and tools (such as a training module), and offer rapid feedback to operating suite staff and physicians about the influence of the briefing on safety and teamwork climate. Anonymous suggestions collected in a box outside the Perioperative Services Department Administrator’s office provided qualitative data. Both sets of information allowed the team to quickly identify and resolve concerns during the pilot period. For example, one anonymous suggestion proposed placing a whiteboard in each of the operating rooms to list the four primary roles and the name of each person in that role for the current case. Studies have shown that knowing the names of other team members greatly improves prevention of adverse outcomes. This simple addition to the Preoperative Safety Briefing added...
tremendous value; more important, this type of rapid cycle change process provided the global framework for problem-solving in the operating suite.

Preoperative Safety Briefing Project

The Preoperative Safety Briefing six-month pilot beginning in February 2002 consisted of several steps.

Program Measures

Measuring clinical outcomes as a result of improved operating suite safety culture is difficult. Unexpectedly poor clinical outcomes in the operating suite that are attributable to human factors are rare, especially in a culture that drives toward zero tolerance of performing wrong-site/wrong procedures. However, various types of risk data were collected and, as a means to measure the program’s progress and success, the following four indicators of safety culture were used: occurrence of wrong-site/wrong procedures, questionnaire results, near-miss reports, and nurse turnover data.

Risk Data

The risk data compiled were the number and severity of Unusual Occurrence Reports; the number of near-miss reports; reports of faulty or missing equipment or instrumentation (or both) with subsequent case delays; nurse retention rates and nursing position openings; concerns and issues raised confidentially via a closed message box in the operating suite; and comments by operating suite team members after cases, as written in an open (ie, nonconfidential) log kept at the front desk.

Although risk reduction was inherent in design of the project, the data were minimally reviewed at each monthly pilot project team meeting to safeguard against unrecognized negative impacts or unintended consequences.

Safety Attitudes Questionnaire

The largest source of data was a series of Safety Attitudes Questionnaires (SAQs) administered to physicians and operating suite staff. Attitude, as measured by validated instruments, can predict work performance and can be changed through training and environmental changes. Attitude in personnel in the healthcare setting can be related statistically to patient outcome; aggregated attitude scores reflect the culture or climate of the organization.

The SAQs used in our pilot were developed by the Center of Excellence for Patient Safety Research and Practice at the University of Texas and have been used in more than 450 hospitals and their departments in the United States, Europe, Australia, and New Zealand. SAQs are designed to assess the following factors that are linked to risk-adjusted patient mortality and nursing turnover: job satisfaction, perceptions of management, teamwork climate, safety climate, stress recognition, and working conditions. Participants read a series of statements and are asked to respond with “Agree Strongly,” “Agree Slightly,” “Neutral,” “Disagree Slightly,” or “Disagree Strongly.” Table 2 shows sample SAQ statements; responses to this subset of statements were used to measure the perceived safety climate of the participant’s clinical area. An SAQ

Table 2. Subset of statements on the Safety Attitudes Questionnaire used to evaluate the perceived safety climate in the perioperative setting

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
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<tbody>
<tr>
<td>I would feel safe being treated here as a patient.</td>
<td></td>
</tr>
<tr>
<td>I am encouraged by my colleagues to report any patient safety concerns I may have.</td>
<td></td>
</tr>
<tr>
<td>Patient safety is constantly reinforced as the priority in this clinical area.</td>
<td></td>
</tr>
<tr>
<td>I know the proper channels to direct questions regarding patient safety in this clinical area.</td>
<td></td>
</tr>
<tr>
<td>Medical errors are handled appropriately in this clinical area.</td>
<td></td>
</tr>
<tr>
<td>The culture of this clinical area makes it easy to learn from the mistakes of others.</td>
<td></td>
</tr>
<tr>
<td>Personnel frequently disregard rules or guidelines (eg, hand washing, sterile field, etc) that are established for this clinical area.</td>
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</table>
was administered in the OCSA in August 2001, which was six months before project design began, and again in September 2002, after completion of the pilot. Each participant was given a survey and asked to return the completed survey in a sealed envelope to the charge nurse. Response rate for the prepilot SAQ was 75% and for the postpilot SAQ was 88%; 59 operating suite staff and 60 surgeons at KP Anaheim Medical Center were surveyed. In addition, a subset of questions from the SAQ was administered to participants monthly during the pilot to track progress.

Results

Improved Safety Indicators

Three wrong-site surgeries were reported in 2001, but none were reported in 2002; in fact, the Orange County Surgical Services Team has not experienced a single wrong-site/wrong procedure incident since the introduction of the Preoperative Safety Briefing. Quality Management analyzed the three incidents in 2001 and determined that they might have been prevented with use of the Preoperative Safety Briefing.

Quality Management monitored the number of reports of near misses and of faulty or missing equipment to measure change in situational awareness and nurturing of a blame-free environment. An increase in the number of near misses reported was assumed to signal that operating suite staff and surgeons were becoming more willing to admit errors; the number of near misses reported increased from zero in 2001 to 5 in 2002. Compared with 2001, reports of faulty or missing equipment and instrumentation decreased slightly in 2002, but the frequency at which operating suite or anesthesia time was extended or cases were delayed or canceled subsequent to issues with equipment may have decreased and is being evaluated. These results suggest that the Preoperative Safety Briefing facilitates early reporting of equipment issues and that this reporting leads to timely solutions that enhance patient care in the perioperative setting and minimize operational costs.

Improved Safety and Teamwork Climate

The improved SAQ scores occurred after the pilot validated the importance of the briefing in changing the teamwork and safety climate in the operating suite; each of the factors linked to risk-adjusted patient mortality and nursing turnover showed statistically significant improvement. Team identification, communication, and collaboration also increased significantly.

The percentage of operating suite personnel who agreed or strongly agreed that the safety climate in the perioperative setting was good increased from 51.1% to 62.9% after completion of the pilot, a substantial increase. Substantial improvement was also seen in operating suite personnel perceived teamwork climate (Figure 2) and in their perception of priority of patient safety in the operating suite, of communication, of their taking responsibility for patient safety, of nurse input being well received, and of medical errors being handled appropriately. In addition, personnel reportedly found it easier to speak up when they identified a problem in patient care and found it easier to discuss mistakes. Throughout the reporting period, the perception of teamwork was somewhat influenced by the discipline and job of participants; physicians consistently gave nurses higher teamwork scores than nurses gave physicians (Figure 3).

Improved Morale

As use of the Preoperative Safety Briefing became more common, morale among operating suite personnel improved—especially among nurses—an improvement that was reflected by increased nurse retention rates (Figure 4). In May 2001, Orange County had 20
open nursing positions, and the turnover rate was 23%. In May 2003, six nursing positions were open, and the turnover rate was 7%.

**Minimal Cost and Change to Organizational Structure**

Minimal fiscal support was required. Support necessary for the initial design and implementation phase of the Preoperative Safety Briefing included a project manager (at 0.25 FTE) and ancillary support time (at 0.25 FTE) and training materials. Nonpersonnel resources included conferences, the implementation toolkit, and training sessions at a total project cost of approximately $49,500. Physician and Labor leadership, after implementation and continued ancillary support time, will be required to sustain the gains at an estimated cost of $15,500. As part of our efforts to sustain the success of the Briefing, KP Orange County has institutionalized the role of the Physician Director of Patient Safety (with administrative time attached) to support a broader culture of safety there. Much of the administrative time spent on this project by the Perioperative Department Administrator, the Quality Management Coordinator, Quality Leader, and Risk Manager was absorbed by their normal daily operations. The operating suite staff members were compensated for attending the steering committee meetings and for attending training sessions.

**Discussion**

As an organization that cares about its members and employees, KP has a responsibility to create and maintain a culture of safety, because “Safety comes first, before quality, service, and profit.” Injuries and errors such as wrong-site surgeries have tremendous personal cost to the patient and employee and are a significant financial liability for KP. In addition, the factors that enable severe errors also lead to decreased morale and poor staff retention rates. Human Factors principles provide a straightforward method for preventing errors by improving team communication and collaboration. Creating a team with a healthy balance between vertical and lateral communication allows team members to identify variation in processes and to develop system modifications to reduce inappropriate variation, which ultimately empowers everyone—surgeon, anesthesiologist, and operating room staff alike—to act as an agent for change.

In 2002, KP Orange County personnel reported that briefings were approximately 1.5 times more common than the year before, and respondents who reported good teamwork climate nearly doubled during this time. Team identification, communication, and collaboration have increased substantially, potential problems are identified and resolved preoperatively, and situational awareness has been heightened as shown by increased reporting of near-miss situations.

After its introduction in 2002, the Preoperative Safety Briefing potentially improved the safety of every patient who had a procedure done in the operating suite at the KP Anaheim Medical Center. In 2002, OCSA membership was more than 340,000, and of the 16,042 operating suite procedures performed in Orange County...
in 2002, 6795 (43%) were done at the KP Anaheim Medical Center.

A small investment was necessary for designing and implementing the change, but the resource allocation was easily absorbed into the existing cost structure and required a minimal, shared commitment among the perioperative team members. The rewards of this change were a clear, shared focus on the patient. The goal was achieved of lessening the gap between positive perception of teamwork by physicians rating nurses and somewhat lower positive perception of teamwork by nurses rating physicians. Greater satisfaction among operating suite staff was indicated by decreased nurse turnover. Increased operational efficiency was indicated by reduced delays in receiving operating suite equipment and reduced case delays or cancellations and an overall heightened awareness of patient safety initiatives.

**Broad-based Participation**

The critical success factor of this project has been the project’s team commitment to designing and implementing these cultural changes in their environment. The multidisciplinary project team consisted of surgeons, operating suite nurses, anesthesiologists, nurse anesthetists, scrub technicians, quality coordinators, and administrators. Janice Bouma, RN, represented the United Nurses’ Association of California, and Ed Marthaler, CRNA, represented the Kaiser Permanente Nurse Anesthetist Association (KPNAA). Five of the 16 members, or approximately 31% of the Steering Committee, represented Labor. From the project’s inception to implementation and refinement, Labor was a true partner. The local Leadership Team’s recognition of the Human Factors principles’ impact on patient and workplace safety and their support through application to other services reaffirm this project’s value to Labor and Labor’s commitment to share in the accountability of developing a safety culture throughout the OCSA. Labor representatives submitted testimonials praising the program (Table 3).

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**Table 3. Testimonials submitted by Labor Representatives after implementation of the Preoperative Safety Briefing**

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<th>Testimonial</th>
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<tr>
<td>“Safety Briefings I believe have done a lot of things particularly for safety in the OR from the scrub tech point of view. It helps me focus on what I should be prepared to do for the procedure. Care goes smoothly when you have all the supplies that you need and the atmosphere in the room is much more enjoyable for all because you know you’re ready. Good communication and teamwork is always better.” — Neria Contreras, OR Technician</td>
</tr>
<tr>
<td>“I think Safety Briefings done before surgery are great! Good for patients and for the OR team. Because of the Briefings, everyone is on the same page and cases run smoothly, with less time for the Circulators running for equipment. I would not want to work in an OR without Human Factors Safety Briefings” — Tommy Encinas, OR Technician</td>
</tr>
<tr>
<td>“I have enjoyed the concept and practice of the Safety Briefing. This is an opportunity for a collegiate atmosphere that can set the tone for each operation, if not the entire day. All of us strive to do our best and safest work for each patient and this exercise can help keep each provider in sync.” — Kathi Ryan, CRNA</td>
</tr>
<tr>
<td>“When the surgeon takes the time for the Safety Briefing prior to starting the case, to address each issue regarding the patient’s surgery with the whole OR team, the whole case flows more smoothly and questions can be addressed prior to the start of surgery. It is nice to hear the expectations of the surgeon, anesthesia, scrub and circulator before the start of surgery, putting us all on the ‘same page.’ All of the above does contribute to the overall safety and well-being of the patient and staff.” — Sharon Romerson, RN</td>
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<tr>
<td>“For the few focused moments the Safety Briefing requires, it has produced so much valuable information for all the surgical team members. Many times either the surgeon or myself has produced new information from the patient or old charts which have changed the patient care. The old saying ‘Oh, by the way, did you know …?’ comes alive in the briefing. Many times this changes our approach in anesthesia and immediate post-op care. It is always reassuring to have one last team focus on the correct side, correct procedures and correct patient. Such a short process—such rewards.” — Ed Marthaler, CRNA</td>
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<tr>
<td>“From a circulating nurse’s point of view, the Human Factors/Safety Briefings begin in the holding area when we verify the procedure with the patient verbally and by marking the operative site. This immediately reassures the patient that we are beginning a process of avoiding mistakes. The process continues in the room with the surgeon present along with the scrub nurse and anesthesiologist. At this time, the team verifies all of the pertinent items from the Human Factors components, and each member of the team is given an opportunity to contribute any information particular to their function. This sharing of parts is what makes for a more of a team atmosphere, although the participation of surgeons varies. Anticipation is one of the catchwords of any surgery nurse. Using the Safety Briefings, the nursing staff receives information that allows us to prepare better for the surgeon’s needs with the goal of reducing unnecessary delays. From a nursing standpoint, we are now proactive rather than reactive to the surgeon’s request and progress of the procedure. ‘Not only are we sharing information about the patient and the procedure, but also the team members are communicating better among themselves. This is a good thing!’ — Helen Burney, RN, and Lori Tokeshi, RN</td>
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**Toward Continued Safety Improvement**

The Preoperative Safety Briefing has become the safety standard norm in the KP Anaheim Medical Center operating suites and will become the norm in our contract hospital operating rooms throughout the OCSA. The project has transitioned from pilot mode to process improvement mode. The goal is to add additional components to the Preoperative Safety Briefing to continue to build the safety culture in the perioperative setting. For example, the team is currently developing and implementing a Postoperative Debriefing and determining how to strengthen briefings at handoffs and breaks. The Regional Coordinating Chief of Anesthesia continues to work with the Chiefs of Anesthesia, Perioperative Depart-
Preoperative Safety Briefing Project

Clinical Contributions

ment Administrators, and Joint Anesthesia Management Committee (JAMCO) to support local implementation throughout the region.

Both the specific implementation of a Preoperative Safety Briefing and the general concept of using Human Factors principles to improve patient safety are highly transferable. Within KP, the Physician Champion, Dr James DeFontes, MD, who is also the Regional Coordinating Chief of Anesthesia, has formally presented the Preoperative Safety Briefing concept at the Perioperative Summit for KP Southern California, the Regional Anesthesia Symposium, the Regional Anesthesia Chiefs of Service Meeting, the Perioperative Departmental Administrators Meeting, and the Anesthesia Departmental Administrators Meeting. Through his discussions with JAMCO and the Chiefs of Anesthesia, an SAQ was administered throughout the KP Southern California Region. On the basis of these results, the Chiefs of Anesthesia and JAMCO supported the recommendation to work collaboratively on opportunities for safety improvements at their local sites and agreed to conduct another survey within a year after improvements were made.

To date, the concept of the Team Briefing has been institutionalized regionally as part of the Procedural Sedation Policy in the KP Medical Care Program, Southern California Region, Policies & Procedure Manual (P&P#: 03-167-01). Similarly, Dr Mark Gow, MD, who is also the KP Orange County Director of Patient Safety, has formally presented to the medical staff at Panorama City and will continue to share successful practices with his colleagues in other service areas. Application of the Preoperative Safety Briefing and Human Factors principles are expected in other perioperative settings in other service areas across the region.

The Preoperative Safety Briefing concept has been applied to other services within the OCSA, such as the Departments of Labor and Delivery and of Radiology, with support from the quality management coordinators. The briefing concept is also part of the Regional Labor Management Initiative, because it is one of the annual goals for JAMCO this year.

Interest has also been expressed from outside KP; inquiries have been received from Harvard University, the University of Michigan, and other health care institutions. Dr Gow and the Perioperative Department Administrator are working with our contract hospitals and other private hospitals, such as the City of Hope, to share this tool with their peers in the community. The project team is also committed to spreading these ideas and practices to other KP Regions.

Conclusions

A healthy team environment serves as the foundation for a conducive environment for change. In OCSA, the net effect of this project has been to transition the operating suite culture away from one of individual advocacy to one of an integrated team mentality that mitigates risks to patients, attains optimal operational efficiency, and empowers all participants to leverage improvements beyond patient safety.

Acknowledgments

Michael W Leonard, MD, Anesthesia, KP Colorado Franklin Medical Center; Suzanne M Graham, RN, PhD, KP California Regions Patient Safety Practice Leader; and Doug Bonacum, MBA, Vice President, Safety Management, provided training. Mark Alan Monroe, RN, KP National Environmental Health and Safety Department, provided statistical analysis. From the University of Texas, J Bryan Sexton, PhD, assisted with data analysis; and William R Taggart, Human Factors Research Project, assisted with training.

References

8. University of Texas Center of Excellence for Patient Safety Research and Practice. Safety attitudes questionnaire (OR version). [Houston (TX):] University of Texas Center of Excellence for Patient Safety Research and Practice; 2002.
Factors Associated with Smoking Cessation Among Quit Smart™ Participants

Abstract

Objectives: To evaluate social and program factors associated with the one-year smoking cessation rate among participants of a smoking cessation program at a managed care organization (MCO).

Methods: As implemented at this MCO, the Quit Smart™ program incorporated group sessions taught by health educators, discount vouchers for nicotine replacement patches, self-help manuals, and a relaxation audiotape. A survey of 97 patients who participated in the program during 1999 or 2000 or both was administered one year after these participants completed the program.

Results: Of the 97 participants, 58 responded to the survey. Nineteen (33%) reported not smoking at one year after completing the program; and 11 (19%) reported that they were smoking-abstinent for 12 months after completing the program. Compared with patients who did not use the nicotine patch, respondents who used the nicotine patch were significantly more likely (OR = 4.42 [1.12, 17.35]) to report not smoking at 12 months after completing the program and to be smoking-abstinent for 12 months after completing the program (OR = 8.31 [1.15-60.22]). Respondents who were exposed to smoking in two or three settings (ie, at home, with friends, at work) were significantly less likely to report smoking cessation at 12 months (OR = 0.12 [0.02, 0.70]) and to have abstained from smoking for 12 months (OR = 0.04 [0.01, 0.42]) than were respondents who were not exposed to smoking in these settings.

Conclusions: The Quit Smart™ program achieved 12-month smoking cessation and abstinence rates comparable with those achieved by other multifactorial programs to promote smoking cessation. Subsidized therapy using the nicotine patch was effective for promoting smoking cessation, rates for users of the nicotine patch are approximately double the quit rates for users of placebo.

Introduction

Population-based studies of smoking cessation programs indicate that, although initial quit rates are high, quit rates decline to approximately 15%-25% at one year. Community- and workplace-based interventions generally report quit rates of a similar magnitude and some report rates as high as 30%. For comparison, the background rate of unassisted smoking cessation is estimated at approximately 7%-8%. Physician interventions that use nicotine gum as an aid to smoking cessation produce one-year quit rates of about 10%. Within managed care organizations, one-year smoking cessation rates as high as 30%-40% have been reported. One of several interventions used in multifactorial health education programs to promote smoking cessation, nicotine replacement therapy is efficacious for promoting and sustaining smoking cessation and is also a cost-effective method of treatment. Controlled studies have shown that quit rates for users of the nicotine patch are approximately double the quit rates for users of placebo.

Controlled studies have shown that quit rates for users of the nicotine patch are approximately double the quit rates for users of placebo.

By Karen M Polizzi, MPH; Douglas W Roblin, PhD; Adrienne D Mims, MD, MPH; Dianne Harris, BS, CHES; Dennis D Tolsma, MPH

Karen M Polizzi, MPH, Doctoral Student, Research Department, KP Atlanta, GA. E-mail: Karen.Polizzi@gatech.edu.
Douglas W Roblin, PhD, Research Scientist, Research Department, KP Atlanta, GA. E-mail: douglas.robin@kp.org.
Adrienne D Mims, MD, MPH, Chief of Prevention and Health Promotion, KP Atlanta, GA. E-mail: adrienne.mims@kp.org.
Dianne Harris, BS, CHES, Member Education Coordinator, KP Atlanta, GA. E-mail: dianne.harris@kp.org.
Dennis D Tolsma, MPH, Director of Research for KP Atlanta, GA. E-mail: dennis.tolsma@kp.org.
of this combined approach is to maximize the number of smokers who can abstain from cigarettes permanently. The Quit Smart™ program consists of six interactive group sessions directed by trained health educators and offered quarterly during evenings and weekends. During the course of the program, participants wean themselves from nicotine by switching to cigarette brands that deliver successively lower levels of nicotine. Participants also receive a $5 discount voucher (redeemable at any KPG pharmacy) for a two-week supply of nicotine patches every two weeks for the duration of the program. Additional materials provided to participants for use during the program include brochures and guides for adopting a smokefree lifestyle; an audiotope designed to promote relaxation; and a patented, realistic cigarette substitute. The fee for the program is $20. Key components of the Quit Smart™ intervention are summarized in Figure 1.

### Study Population

The study population consisted of all participants in the Quit Smart™ program during the Fall 1998 (n = 62) and Spring 1999 (n = 35) sessions who remained enrolled with KPG at 12 months after attending the last program session.

### Participant Survey

A short survey of the study population was administered by telephone to ascertain one-year smoking cessation status and to identify factors promoting or inhibiting smoking cessation in the 12 months after completing the Quit Smart™ program.

Instrument items and scales were developed through an iterative process. We initially reviewed the smoking cessation literature for sample items and for factors associated with promoting or inhibiting smoking cessation. The survey instrument included items about the following topics:

- Tobacco smoking in the 12 months after completing the Quit Smart™ program;
- Motivation for enrolling in the program;
- Aids for smoking cessation, whether used in the Quit Smart™ program or otherwise known to be effective (eg, nicotine patches);
- Other behavioral and environmental factors associated with promoting smoking cessation (eg, regular physical exercise) or inhibiting smoking cessation (eg, smoking by other family members);
- Symptoms experienced by program participants after completing the program and which are typically associated with newly begun abstinence from tobacco; and
- Basic demographic and socioeconomic characteristics of program participants.

The survey instrument was designed to be completed within 10-15 minutes. A draft instrument was administered to a small convenience sample of colleagues (smokers and former smokers) for assessing flow and clarity of the instrument. The final survey instrument included revisions suggested by the preliminary survey results. The final survey instrument and the protocol for its administration were reviewed, approved, and monitored by the KPG Institutional Review Board.

For the Fall 1998 group, the survey was administered during December 1999; for the Spring 1999 group, the survey was administered during May 2000. Approximately two weeks before receiving the initial telephone call, each potential respondent was mailed a letter containing information about the survey. As many as five attempts were made to contact each potential respondent. A total of 58 participants completed most of the survey (response rate of 60%).

### Table 1. Characteristics of 58 participants in smoking cessation program

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Overall</th>
<th>Not smoking at 12 months</th>
<th>P</th>
<th>Smothefree for 12 months</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 25-47 years (50.0%)</td>
<td>19 (32.8)</td>
<td>0.78</td>
<td>11 (19.0)</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td>Age: 48 years and older (50.0%)</td>
<td>9 (32.1)</td>
<td>0.49</td>
<td>4 (14.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female (74.1%)</td>
<td>6 (35.7)</td>
<td>0.35</td>
<td>3 (20.0)</td>
<td>0.91</td>
<td></td>
</tr>
<tr>
<td>Gender: Male (25.9%)</td>
<td>3 (30.2)</td>
<td>8 (18.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity: White (53.6%)</td>
<td>8 (26.7)</td>
<td>0.23</td>
<td>6 (20.0)</td>
<td>0.94</td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity: Black (46.4%)</td>
<td>10 (38.5)</td>
<td>0.23</td>
<td>5 (19.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education: High school or less (25.9%)</td>
<td>3 (20.0)</td>
<td>0.03</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education: Some college, college graduate, or postgraduate (74.1%)</td>
<td>16 (37.3)</td>
<td>11 (25.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income (1998): Less than $50,000 (47.3%)</td>
<td>7 (26.9)</td>
<td>0.39</td>
<td>5 (19.2)</td>
<td>0.89</td>
<td></td>
</tr>
<tr>
<td>Household income (1998): $50,000 or more (52.7%)</td>
<td>11 (37.9)</td>
<td>6 (20.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status: Married (70.9%)</td>
<td>13 (33.3)</td>
<td>0.77</td>
<td>9 (23.1)</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>Marital status: Single (29.1%)</td>
<td>6 (37.5)</td>
<td>2 (12.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Probabilities derived from a χ²(1df) test of two levels of the patient characteristic with smoking cessation status.

Note: Numbers of respondents by characteristic may be less than overall number because of missing values for the characteristic.
Measures

The study had two principal dependent variables: smoking cessation status at 12-month follow-up and smoking cessation status for the entire 12 months after participating in the program. Smoking cessation at 12 months after last attending the Quit Smart™ program was assessed by response to the following item: “Do you currently smoke cigarettes?” A negative response was interpreted as indicating nonsmoking at 12 months. The second dependent variable—ie, whether or not the respondent was smokefree for the entire 12-month period—was ascertained for respondents who responded negatively both to the initial item and to another item: “Did you smoke cigarettes at any time following the Quit Smart™ program?” Respondents who answered “no” to smoking at any time were considered to be smokefree for 12 months. Both dependent variables were coded as binary (1 = not smoking at 12 months or 1 = 12 months smokefree, 0 = otherwise).

The study had three principal independent variables: use of aids to quit smoking, cumulative number of settings with smoking exposure, and level of physical activity. Use of aids to quit smoking was assessed among all respondents by asking, “What techniques did you use to quit smoking?” Responses included: “Cold turkey, will power” and “Nicotine patch.” Both variables were coded as binary (1 = used the technique). Smoking exposure at home, among friends, and at work was ascertained. Exposure at home was measured by asking if the respondent lived in a house with others and whether or not any of these persons smoked. Exposure among friends was assessed by asking how many of the respondent’s five closest friends smoked. Exposure at work was ascertained by asking if the respondent was employed and whether or not any of the respondent’s five closest colleagues smoked. Each of these three variables was coded as binary (1 = exposed). A cumulative measure of smoking exposure was also computed as the sum of the settings with exposure (0, 1, 2, or 3). Level of physical activity was ascertained from a 5-level response (“Rarely or not at all” through “Every day”) to the question “How often do you exercise?” We recoded this item into a binary variable of “Every day” versus “Less than every day.”

Statistical methods

The 12-month quit rate was calculated as the number of respondents who were not smoking at the time of interview divided by the total number of respondents who completed the survey. The 12-month abstinence rate was calculated as the number of respondents who remained smokefree for the entire 12 months after completing the program divided by the total number of respondents.

Association of the independent variables with respondent status as a 12-month quitter or with respondent status as a 12-month abstainer or not was evaluated by using a χ² test of significance (α = 0.05). Because the sample size was small, we considered any association with an α-level of 0.15 to be marginally significant.

Logistic regression for each of the two dependent variables was estimated to assess competing effects of factors that help smoking cessation and factors that inhibit smoking cessation.

Analyses were performed using SAS (Statistical Analysis Software) Version 6.12 (SAS Institute, Cary NC).

Results

Respondent characteristics

Median age of respondents was 48 years (Table 1). The population of respondents was predominantly (nearly 75%) female and consisted of approximately equal percentages of whites and African Americans. Most respondents had some college education, reported an annual household income of at least $50,000, and were married. Overall, respondents resembled the KPG adult membership except for the distribution by gender, which in the general KPG adult membership is approximately equal.
Personal choice was indicated by 71% of respondents as the principal reason for enrolling in the Quit Smart™ program (data not shown in tables). Physician recommendation to enroll was the principal reason given by 21% of respondents. Only 7% indicated that availability of the nicotine patch was their principal reason for enrollment. Neither the 12-month quit rate nor the 12-month abstinence rate was significantly associated with respondents' reasons for enrolling in the Quit Smart™ program.

Smoking Cessation
The 12-month quit rate was 32.8% (95% CI=21.4%-46.5%; Table 1). The 12-month smoking abstinence rate was 19.0% (95% CI=10.3%-31.8%). The 12-month quit rate was not significantly associated with any of the demographic, racial or socioeconomic characteristics of respondents. The 12-month abstinence rate differed significantly only by level of education of respondents (p = 0.03). None of the respondents with a high school education or less abstained from tobacco use for the entire 12 months after enrollment in the Quit Smart™ program.

Of the 39 respondents who indicated that they were smoking at 12 months after last attending the Quit Smart™ program, 67% indicated that they had quit smoking for a limited time after completing the Quit Smart™ program (data not shown in tables). At the time of survey, current smokers were, on average, smoking 13 cigarettes (half a pack) per day. Mean duration of abstaining from smoking was 2.6 months.

Factors Promoting or Inhibiting Smoking Cessation
The 12-month quit rate was marginally associated with several environmental factors reported by respondents (Table 2). The 12-month quit rate among respondents who reported exposure to smoking in two or more settings was 18.2%, lower than the 46.7% rate for respondents who were not exposed to smoking in any setting (p = 0.06). The 15.4% quit rate for respondents who were exposed to smoking at home was lower than the 37.8% quit rate for respondents who were not exposed to smoking at home (p = 0.13). The 22.6% quit rate for respondents who were exposed to smoking among friends was lower than the 44.4% quit rate for respondents who were not exposed to smoking among friends (p = 0.08). Among respondents who reported using the nicotine patch as an aid for quitting smoking, the 12-month quit rate (41.9%) was greater than the 12-month quit rate (22.2%) among respondents who did not use the nicotine patch (p = 0.11). The 12-month abstinence rate among respondents who reported exercising daily (38.5%) was higher than the abstinence rate among respondents who exercised less frequently (13.3%) (p = 0.04). For respondents who were exposed to smoking in at least two settings, the 12-month abstinence rate (9.1%) was lower than the abstinence rate for respondents who were not exposed to smoking in any setting (40.0%) (p = 0.03). The 12-month abstinence rate was most adversely associated with exposure to smoking among friends (6.5%) of any setting in which respondents were exposed to smoking (33.3%) (p = 0.01).

For exercise frequency, use of the nicotine patch, and settings in which respondents were exposed to smoking, we obtained adjusted odds ratios for 12-month smoking cessation status (Table 3). Compared with respondents who did not use the nicotine patch, respondents who used the nicotine patch were significantly more likely (OR = 4.42 [1.12, 17.35]) to report not smoking at 12 months and to abstain from smoking for 12 months (OR = 8.31 [1.15-60.22]). Compared with respondents who were not exposed to smoking at home, among friends, or at work, respondents who were exposed to smoking in two or three settings were significantly less likely to report smoking cessation at 12 months (OR = 0.12 [0.02, 0.70]). Similarly, respondents who were exposed to smoking in either one, two, or three settings were significantly less likely (OR = 0.09 [0.01, 0.42] and 0.04 [0.01, 0.42], respectively) to abstain from smoking for 12 months than were participants who were not exposed to smoking in these three settings.

Discussion
As implemented at KPG, the Quit Smart™ program yielded a 12-month quit rate of 33%

---

**Table 3. Adjusted odds ratios obtained from logistic regression analysis of smoking cessation**

<table>
<thead>
<tr>
<th></th>
<th>Not smoking at 12 months</th>
<th>Smokerfree for 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted odds ratio</td>
<td>Lower 95% CI</td>
</tr>
<tr>
<td></td>
<td>Adjusted odds ratio</td>
<td>Lower 95% CI</td>
</tr>
<tr>
<td>Used nicotine patch as aid to quit smoking</td>
<td>4.42*</td>
<td>1.12</td>
</tr>
<tr>
<td>Exposed to smoking in only one setting</td>
<td>0.47</td>
<td>0.11</td>
</tr>
<tr>
<td>Exposed to smoking in two or three settings</td>
<td>0.12*</td>
<td>0.02</td>
</tr>
<tr>
<td>Exercise daily</td>
<td>2.19</td>
<td>0.55</td>
</tr>
<tr>
<td>Model goodness of fit:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mallows C</td>
<td>0.73</td>
<td>0.87</td>
</tr>
</tbody>
</table>

* Indicates that adjusted odds ratio is significantly different from 1.00 for p < 0.05.

b Indicates that the model goodness-of-fit estimate is significant for p < 0.05.

Reference group: did not use nicotine patch; not exposed to smoking at home, among friends, or at work; and exercise less than daily.
and a 12-month abstinence rate of 19%. These rates resemble those achieved in other multifactorial health education programs promoting smoking cessation at other MCOs. Use of the nicotine patch promoted both smoking cessation and smoking abstinence at 12 months, whereas continued exposure to smoking—whether at home, among friends, or at work—inhibited both smoking cessation and smoking abstinence at 12 months. This importance of the nicotine patch (and other forms of nicotine replacement) for facilitating smoking cessation is consistent with results reported for clinical trials as well as for other observational studies of smoking cessation techniques. Other studies have affirmed the association between exposure to smoking and temptation to smoke, failure to quit smoking, and smoking relapse among former smokers.

The main strength of the Quit Smart™ smoking cessation program is its combination of proven methods for aiding smoking cessation. Comments solicited from survey respondents indicated that the program was well received by those who attended it. Even respondents who continued to smoke indicated that they were very satisfied with the program overall.

That smoking cessation programs are cost-effective—both in general and with regard to specific strategies—is widely accepted. The cost of an entire smoking cessation program may be justified even if only a low percentage of program participants achieve abstinence.

In summary, the Quit Smart™ program was a success from a cost-benefit standpoint as well as from a health education standpoint. Although the response rate to the survey was relatively high (60%), the number of respondents was small. This small sample size limited power to detect statistically significant differences (for $p < 0.05$) in factors promoting or inhibiting smoking cessation and resulted in wide confidence intervals even when a difference was significant ($p < 0.05$). Moreover, the study sample included only KPG members who completed the Quit Smart™ program and remained KPG members at 12 months after completing the program. If smoking cessation or abstinence rates differ between survey respondents and nonrespondents, between study participants who remained KP members and study participants who disenrolled from KPG, or between participants who completed the Quit Smart™ program and those who did not, then our current estimates of the Quit Smart™ program could overestimate or underestimate the true intervention effects. In addition, we used patient-reported measures for estimating 12-month quit and abstinence rates. Although self-reported measures are generally consistent with biochemical measures of smoking status, self-reported measures may tend to overstate the socially desirable response (ie, smoking cessation). Because this study was conducted as part of a quality improvement initiative, we did not include a control group (eg, patients randomly assigned at entry to the Quit Smart™ program or no intervention).

In summary, the Quit Smart™ program was easily incorporated into the prevention and health promotion objectives of the Kaiser Permanente Georgia Region. Of program participants responding to a survey at 12 months after completing the program, 35% had quit smoking; and 19% reported that they had abstained from smoking for the entire 12 months. Use of the nicotine patch significantly promoted smoking cessation, whereas exposure to smokers in multiple settings significantly inhibited smoking cessation.

The cost of an entire smoking cessation program may be justified even if only a low percentage of program participants achieve abstinence.

The main strength of the Quit Smart™ program is widely accepted. That smoking cessation programs are cost-effective—both in general and with regard to specific strategies—is widely accepted. The cost of an entire smoking cessation program may be justified even if only a low percentage of program participants achieve abstinence.

References


Factors Associated with Smoking Cessation Among Quit Smart™ Participants

To Choose an Action

His mother often said, When you choose an action, you choose the consequences of that action. She had emphasized the corollary of this axiom even more vehemently: when you desired a consequence you had damned well better take the action that would create it.

—Lois McMaster Bujold, b 1949, Science Fiction and Fantasy writer
“Bayon Face 2”
By Beverly Brott, MD

More of Dr Brott’s artwork can be seen on page 70.
The Myth of the Preventive-Only Visit

By Patricia E Boiko, MD, MPH
Alethea Lacas, MD

Abstract
Context: The annual physical examination is a staple of North American medicine. Medicare does not pay for such visits, and the United States Preventive Services Task Force designates these visits as preventive services.

Objective: To understand the expectations of receptionists, patients, and physicians as well as their reasons for scheduling a health maintenance visit and to clarify the expectations of patients and providers regarding delivery of clinical preventive services during these visits.

Design: Cross-sectional survey of patients (20 years and older) in a group practice who called to request an appointment that receptionists interpreted as a health maintenance visit.

Main Outcome Measures: Description and differences between expectations of receptionists, health care practitioners, and patients regarding expectations for the periodic health maintenance visit.

Results: The study included 185 patients between ages 21 to 85 years, for whom a period health visit was scheduled by receptionists when the patient called to ask for a “physical,” “annual exam,” “general checkup,” or “Pap [smear].” Of the 185 patients, 126 (68%) described acute or chronic complaints. Patients and clinicians expected acute and chronic disease care to occur during the health maintenance visit. Patients expected health maintenance visits to last longer than clinicians expected these visits to last (p < 0.001). No significant difference was seen between expectations of patients and those of clinicians about providing preventive care, blood tests, other laboratory tests, care for chronic or acute complaints, or prescription refills during the health maintenance visit.

Conclusion: Although the periodic health visit has been given an assortment of names to indicate that the visit is intended for prevention, patients consider the visit to be an opportunity to ensure that all their health care needs are met.

Introduction
The annual physical examination (health maintenance visit) is a staple of North American medicine and continues to be popular among the general public. Results of a 1984 survey showed that most respondents wanted an annual physical examination, also called a “health maintenance visit,” “well visit,” “routine checkup,” “physical examination,” or “periodic health visit.” Medicare does not pay for health maintenance visits but pays for some preventive services.

The United States Preventive Services Task Force (USPSTF) has named such visits “periodic health visits” intended for delivery of preventive services, and the Task Force believes that visits devoted entirely to health promotion and disease prevention facilitate delivery of many clinical preventive services and even recommends that health maintenance should be considered at every visit. However, the Task Force stops short of recommending any frequency for visits. The proportion of patients receiving a “routine checkup” has been used as an indicator of quality in health care, but reimbursement is often based only on delivery of specified preventive services.

Patients schedule appointments with a physician to arrange care for acute or chronic illness, to obtain answers to health-related questions (whether concerning the patients themselves or their families), and to obtain preventive health services. Patients do not necessarily regard the annual or periodic visit as an opportunity to obtain preventive care separately from acute and chronic care.

On the basis of their perception of a patient’s needs or desires, medical office receptionists are responsible for translating that patient’s expressed needs into an appropriate appointment. Describing an appointment as a “health maintenance visit” creates for patients, clinicians, and medical assistants an expectation of what will occur during the visit.

To date, no research has both ascertained the expectations of receptionists, patients, and physicians before the health maintenance visit and determined afterward whether and how these expectations were actually met. The nonprofit health maintenance organization (HMO) model...
is an ideal setting for studying the
appointments for health maintenance
visits, because receptionists and clini-
cians working in this setting have no
monetary incentives either to sched-
ule or not to schedule these visits. 12

The objective of this study was to
identify the expectations of recep-
tionists, patients, and physicians and
the reasons for scheduling a health
maintenance visit.

**Methods**

**Setting**

The study setting was a suburban
group practice of a 300,000-mem-
ber nonprofit staff-model HMO in
Washington State. One team, which
had a high rate of health mainte-
nance visits, consisted of four fe-
male physicians (2.4 full-time
equivalents) and one nurse practi-
tioner plus two male physicians
from another team who were cho-
en from a clinic with four teams
and approximately 35,000 members.

Members of the HMO pay no fee
for preventive-only health mainte-
nance visits and thus have an in-
centive to schedule such visits.

The HMO’s human subjects In-
stitutional Review Board and sci-
entific review committees approved
the study.

**Table 1. Contents of surveys administered to study participants**

<table>
<thead>
<tr>
<th>Type of survey</th>
<th>Question asked on survey</th>
<th>Possible answers</th>
</tr>
</thead>
</table>
| Patient Expectation Survey (administered before health maintenance visit) | “What do you expect to occur during a physical exam?” (circle all that apply) | I expect the physician to:  
• Order tests and blood work  
• Counsel me about my health and ways to prevent illness  
• Discuss my chronic health condition(s)  
• Address my acute (recent) problem(s)  
• Examine whichever body parts are appropriate to keep me healthy  
• Examine my (circle all that apply): (a) head, eyes, ears, nose, and throat; (b) thyroid; (c) heart, chest, and lungs; (g) abdomen; (h) skin  
• Refill my prescribed medication(s)  
• Other |
| Patient Expectation Survey (administered before health maintenance visit) | “How long do you expect a physical exam to last?” (circle one) | • 5 minutes  
• 10 minutes  
• 15 minutes  
• 20 minutes  
• 30 minutes  
• 40+ minutes |
| Health Questionnaire | “What are your main reasons for today’s visit?” | Checkup  
• Feeling ill  
• Other |
| Health Questionnaire | “What are your most important prevention concerns for today’s visit?” | [Fill in the blank] |
| Health Questionnaire | “Please list other health concerns so that we can plan how to address them.” | [Fill in the blank] |
| Adult Health Questionnaire | Clinician checkmarks boxes indicating anatomic structures examined: head, eyes, ears, nose, throat; thyroid; heart and lungs; breasts; genitalia; and pelvic organs; abdomen; skin. | Examined, not examined, not applicable |
| Provider Survey (administered after health maintenance visit) | “What were your expectations for this physical exam?” (circle all that apply) | • Refill prescribed medications  
• Discuss chronic conditions  
• Discuss preventive care  
• Order diagnostic tests, including blood tests  
• Attend to acute problems  
• Examine head; (including eyes, ears, nose, throat) heart, chest, and lungs; abdomen; pelvic organs and genitalia; extremities and back; skin |
Patient Population and Selection
The study population included registered patients aged 20 years and older who called to request an appointment for what receptionists interpreted as a health maintenance visit.

Using a standard script that described the study, four receptionists asked participants if they would be willing to participate in the study. Only two types of data describing nonparticipants—ie, age and sex—were retained in the database. Patients who agreed to participate in the study received a consent form; a pretested, semistructured survey of initial expectations; a senior health questionnaire (SHQ); and an evidence-based, validated health assessment questionnaire, the Adult Health Questionnaire (AHQ). The sample consisted of all patients who completed these surveys and signed the consent form. The four receptionists scheduled health maintenance visit appointments with clinicians in the study.

Qualitative Data on Expectations
A trained research assistant directly observed the four receptionists to determine their expectations. Before the start of the study, the research assistant conducted open-ended, semistructured interviews with receptionists on a one-on-one basis to evaluate their appointment-making behavior as well as patients’ requests for appointments.

HMO expectations were determined from the cover letter and instructions for the AHQ that were routinely sent to nonparticipants before their scheduled health maintenance visit. Governmental and medical insurance expectations were derived from the US Department of Health and Human Services’ publication “Your Medicare Benefits” and the Premera Blue Cross Web site, customer service representatives, and the USPSTF Guide.

Survey Instruments
The AHQ, SHQ, and pretested semistructured survey identified two elements: the patient’s reason for scheduling a periodic health visit and the patient’s expectations of that visit (Table 1). A survey identified by only the research subject number and accompanied by a stamped return envelope was mailed to participants after the visit to measure patient satisfaction with the visit. Clinicians’ preappointment expectations and postappointment satisfaction with the visit were measured by the clinician survey, which was attached to the patient’s chart before the visit and was identical to the patient expectations survey.

Data Analysis
Statistical analysis was performed using SPSS 10.1 for Windows (SPSS Inc, Chicago, IL). Receptionists’ observations, interviews, and patients and clinicians’ written responses were analyzed by thematic analysis and by basic content analysis. Receptionists’ themes were validated by feedback received from the receptionists in response to an anonymous semistructured questionnaire with summary of themes.

Differences between clinicians’ expectations and patients’ expectations were calculated for continuous data (time of visit duration) using a paired t test. For categorical data, the Wilcoxon signed rank test for paired samples was done to determine agreement between pairs of clinicians and patients. Multivariate logistic regression was used to determine whether patients’ expectations were associated with age, sex, ethnicity, or education. Results were considered significant at a level (p = 0.05).

Results
A pilot study was conducted from July to September 1999; the main study was conducted from February 2000 to May 2001. Receptionists recorded 308 potential subjects during the main study. Without receiving any formal guidance defining a health maintenance examination, receptionists used three types of requests to schedule a health maintenance examination: requests for particular types of visits (eg, physical, checkup, annual examination), requests for particular types of preventive services (eg, Papanicolaou smear, mammography), and requests for appointments regarding particular types of problems (eg, existence of multiple coexisting problems, need for diabetes-related blood tests). All four receptionists scheduled a health maintenance visit for patients whose requests mentioned any of the following phrases: “physical,” “annual exam,” “general checkup,” or “Pap.” Other expressions interpreted by some receptionists as cues for scheduling a health maintenance visit included “blood work,” statements listing a number of health concerns, and “mammogram.” One receptionist used a computerized appointment system to determine when the patient last had a health maintenance visit and recommended such a visit for patients who stated that “it has been a while” since their most recent health maintenance visit.

In whatever terms patients expressed their needs, all patients in the study accepted a health maintenance visit appointment, and 185 (60%) of these patients completed the study. No significant difference was seen between age of participants and age of nonparticipants (ie, patients who declined to participate in the study). Proportionally more men than women declined to participate in the study. A higher proportion of women than men called
Our findings indicate that the routine medical checkup solely for preventive care is uncommon.

for health maintenance visit appointments. Data on patient expectations were collected and analyzed for 185 subjects.

Patients and clinicians expected that acute and chronic medical conditions would receive care during the health maintenance visit, but the HMO did not have such an expectation. Instead, the HMO classified the visit as being scheduled for prevention-only activities. No significant difference was seen between expectations expressed by patients and clinicians that preventive care, blood testing, lab testing, care for acute or chronic medical conditions, or medication refills would be provided during the health maintenance visit. No relation was seen between patients’ education, age, sex, or ethnicity and their expectations for preventive care, acute care, or examination of the head, eyes, ears, nose, throat, thyroid, or abdomen.

Subjects older than 65 years and their clinicians expected the health maintenance visit to include chronic care (p < 0.01) and blood tests (p < 0.001). This conclusion was reached by analysis which controlled for sex, ethnicity, and education. These subjects more frequently expected examination of their chest and lungs (p = 0.03) or skin (p < 0.002); refills of medications (p < 0.02); and more time for the visit (p < 0.002).

Analysis which controlled for sex, education, and ethnicity showed that subjects older than 65 years expected pelvic and genital examinations less often than did subjects younger than 65 years. Women of all ages expected breast examination significantly (p < .001) more often than did men. Subjects expected examination of their head, eyes, ears, nose, throat (HEENT), and genitals significantly (p < .001, p < .02) more often than clinicians either expected or provided. However, patients and their clinicians had the same expectations for examination of the heart, chest, lungs, abdomen, and skin. Significantly (p < .01) more patients than clinicians expected pelvic examination to be done. Patients expected a mean 27-minute duration for health maintenance visits, whereas clinicians expected the duration to be a mean 24 minutes (p < 0.001).

Of the 195 patients who completed the study, 126 (66%) were symptomatic with various acute and chronic problems. Patients’ expectations for the health maintenance visit were met: 92% of study subjects expressed satisfaction or strong satisfaction with the visit.

Discussion

Our findings indicate that the routine medical checkup solely for preventive care is uncommon. As in other studies,20,21 patients clearly expected preventive care at these visits but also expected management of chronic and acute problems. Patients usually do not schedule appointments unless they have medical problems; and they want these problems addressed at the scheduled visit. In the current setting, prevention must be fitted into (or around) visits for other types of care.

The cost of prevention-only “health maintenance” visits is not reimbursed by Medicare or by other health insurance, but the most effective types of prevention intervention (such as colon cancer screening, smoking cessation counseling, and hearing evaluation) do not require a health maintenance visit. Only a few physical maneuvers (e.g., blood pressure testing and Papanicolaou smears) are recommended for prevention. The USPSTF recommends that intervention be conducted on the basis of “periodic examination of asymptomatic individuals.” However, most patients in other studies,4 as well as in the current study, had symptoms and expected all their health care needs to be met at periodic health maintenance examinations. In our study, patients and clinicians expected that health maintenance visits would include preventive care, blood tests, other laboratory tests, care for chronic or acute medical conditions, and medication refills. No relation was seen between the education, age, sex, or ethnicity of subjects and their expectations for preventive or acute care.

Our study was limited to 185 subjects aged 21-85 years, most of whom were white, educated, female members of a nonprofit HMO in an urban setting. Our results thus might not be generalizable to other populations.

The study did have internal and external validity, however. More women than men expected breast examinations, and expectations varied with age, as would be expected (internal validity). Our study results agreed with results of other studies22,23 inasmuch as women in our study made appointments for preventive health care more often than did men (Table 2). Moreover, the expectations expressed by patients in our study were similar to those stated in another study, conducted in Sweden,24 and in a study conducted in Boston, San Diego, and Denver.25

In the Swedish study,24 patient expectations for a health maintenance visit ranged from undergoing tests to conversing with the physician. The opportunity to ask about complaints and diseases was believed to be an essential part of the visit.21 In a survey conducted in Boston, San Diego, and Denver,25 activities that patients and physicians expected at the health maintenance visit—preventive services, blood tests, and examination of various body parts—were similar to those expected by patients and physicians in our study.
In our study, patients expected examination of their head, eyes, ears, nose, throat, and genitals significantly more often than clinicians either expected to provide or actually provided; and significantly more patients than clinicians expected pelvic examination to be done. These differences in expectations was similar to differences shown in another study, where examination of head, eyes, ears, nose, throat, and genitals was expected by 80% of patients but was provided at only 10% of visits; and where pelvic examination was expected by 95% of patients but was provided at only 47% of visits.3

The USPSTF preventive health guidelines4 do not include examination of the head, eyes, ears, nose, throat, and genitals. Medical history is the only basis on which the task force recommends screening older adults for hearing impairment. At the HMO where our study was conducted, clinicians follow a guideline recommending that women at low risk for cervical cancer receive Papanicolaou testing every two years. Thus, female patients seen in this particular practice may expect pelvic examination (Papanicolaou smear) more often than do their physicians. However, our data did not allow us to determine whether the women who expected but did not receive pelvic examinations were the ones who failed to meet the guidelines for receiving the examination.

At the HMO in our study, patients are not charged a visit fee for preventive health visits. Removing the barrier of cost has been shown to improve compliance with prevention.25 Another study26 found that the desire for an annual physical examination decreased substantially when respondents were asked if they would pay $150 for the visit. In that study, no difference in desire for a health maintenance visit was seen between respondents enrolled in HMOs and patients who had another way to pay for health care.2 However, patients at the HMO in our study may be encouraged to use the health maintenance visit for all types of care, because preventive visits are the only type of visit for which the HMO does not charge a copay.

The difference between patients and their clinicians in expected visit duration (27 minutes versus 24 minutes) was significant (p < .001) as determined from matched provider-patient pairs. Patients and physicians in a focus group study wanted an “annual checkup” because they believed that it permitted more thorough evaluation than did a regular office visit and also built trust. The physicians considered the checkup an organizational strategy to address preventive care as well as to get everything done.20 In our study, 92% of subjects reported being satisfied or strongly satisfied that their expectations for the visit were met.

Receptionists are the key factor in whether a patient gets a health maintenance visit or another type of visit. For patients who expect more time to address multiple complaints, receptionists can translate the patient’s desire for more time into an appointment for a health maintenance visit. To address differences in expectations, an alternative scheduling system was tested, wherein receptionists were trained in “problem-based scheduling,”26 in that study, receptionists matched patients’ medical complaints to a simple time scheme for appointments. This scheduling system produced less wait time in the waiting room as well as a more efficient flow of patients and could also address expectations more accurately. In addition, multiple patient concerns could be addressed during longer visits. Exploring a patient’s agenda at the beginning of a visit did not decrease the efficiency of a visit when measured by visit length and amount of work done. With an increased number of concerns addressed, the time was longer overall, but the amount of time per problem did not increase.26

In addition, exploring a patient’s agenda at the beginning of a visit enables clinicians both to avoid the need to address late-arising concerns and to avoid missing opportunities to gather important information.25,26 Nonetheless, interactive online health risk appraisal, telephone interventions for smoking cessation, and mailed screening tests (eg, fecal occult blood tests) may be more efficient and effective ways of delivering preventive services than a health maintenance visit.

No patient in our study called the HMO to request a “health maintenance visit,” “well visit,” or “periodic health visit” as depicted by the national organizations or by the study HMO. Instead, receptionists translated patient requests for a

### Table 2. Demographic characteristics of 185 patients who requested a health maintenance appointment and were invited to participate in study

<table>
<thead>
<tr>
<th></th>
<th>Participants</th>
<th>Nonparticipants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Range 21-85 years (mean 52 years)</td>
<td>Range 20-81 years (mean 50 years)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>20% men (n = 36)</td>
<td>25% (n = 32)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>White (85%), Asian (6%), Black (2%), Hispanic (1%), Multiracial (1%)</td>
<td>75% (n = 95)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>High school (11%), some college (19%), college (19%), graduate school (19%)</td>
<td></td>
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Removing the barrier of cost has been shown to improve compliance with prevention.
“physical,” “annual exam,” “general checkup,” or “Pap” into health maintenance visits. Whatever its name, however—and the health maintenance visit has been called many names to indicating its preventive intent—patients consider this type of visit an opportunity to meet all their health care needs. ❖

Acknowledgments
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References
When Should Patients Receive the Pneumococcal Vaccination? 
Case Example and Suggestions

Introduction
Pneumococcal disease is a major cause of mortality preventable by immunization, yet pneumococcal immunization is underutilized. Influenza and pneumococcal disease accounted for approximately 3400 deaths per year in the US senior population between 1990 and 1999. In such cases, death results from pneumonia, meningitis, and bacteremia but can be prevented with a safe vaccine. Nonetheless, many people who could benefit from immunization have not yet received the vaccine.

Case Description
A colleague asks your opinion about providing pneumococcal vaccine for a patient scheduled for discharge from the hospital. The patient, a 78-year-old African-American woman with hypertension and diabetes, was admitted for chest pain. The coronary artery disease that led to the admission has been stabilized such that she is ready for discharge home. In reviewing the patient’s medical history, your colleague noted that the patient had not received two preventive care services: screening for colon cancer and pneumococcal vaccination. Your colleague wonders if the patient should receive the vaccine before she leaves the hospital. When asked whether she had been vaccinated, she said she did not know that she needed the vaccine.

Recommendations
The Advisory Committee on Immunization Practices (ACIP) currently recommends that certain members of the population receive the pneumococcal immunization. This population subset includes all persons older than age 65 as well as people between ages 2 years and 64 years who have any of several chronic diseases: chronic cardiovascular disease, including congestive heart failure and cardiomyopathy; chronic pulmonary disease, except asthma; diabetes mellitus; alcoholism; chronic liver disease, including cirrhosis; cerebrospinal fluid leakage; and persons who are immunocompromised. People older than age 65 years who received their initial dose of vaccine before age 65 years should receive a second dose after five years have elapsed. Patient recall is sufficient to determine the status of immunization. Patients who do not recall receiving the vaccine should be immunized. Serious side effects from repeated immunization in a short interval have not been reported.

The Healthy People 2000 goal of vaccinating 60% of people older than 65 years of age was met only in 2001. According to a 2001 survey conducted in the United States, 67.1% of non-Hispanic whites, 39.4% of non-Hispanic blacks, and 41.6% of Hispanics residing in the United States were immunized. Immunization rates were directly related to higher number of years of education, frequent visits to a personal physician, income level, and race/ethnicity. The primary reason people offered for not being vaccinated was that they were not informed that they needed the vaccine. The reason why prevalence of vaccination is lower among certain races is unclear but does not appear to be related to income, education, or number of medical visits.

Strategies should be devised and implemented to increase vaccination rates. In the Veterans Administration system, use of standing orders effectively increased immunization rates for influenza vaccine despite race or other social variables. Coupling information about the pneumococcal vaccine with an influenza campaign would be similarly effective because both sets of information target the same groups of high-risk people: those older than 65 years of age and those with chronic medical conditions (except asthma).

A 1997 analysis of cost-effectiveness showed that pneumococcal vaccine was more cost-effective with
regard to Quality-Adjusted Life-Years Saved (QALYS) than other well-accepted prevention screening methods, such as those for colon cancer screening. Cost-effectiveness of pneumococcal immunization was clearly evident for all adults older than 65 years, regardless of comorbid conditions. Cost-effectiveness of pneumococcal immunization was clearly evident in one subset of patients: non-Hispanic blacks aged 50 to 64 years. This finding resulted from the higher prevalence of coincident chronic disease in blacks aged 50 to 64 years compared with the general population in the same age range. Although vaccination for this group is not currently recommended, the finding of cost-effectiveness raises the question of whether immunization recommendations should be modified.

**Specific Treatment Recommendations**

In the case described above, I would recommend vaccination of the patient at discharge from the hospital. Because she is already older than 65 years, she will not need a second dose in the future. Documentation of vaccination should be included in the discharge note so that the outpatient medical records are updated for future reference.

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**References**


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**Twenty Drugs**

The young physician starts life with twenty drugs for each disease, and the old physician ends life with one drug for twenty diseases.

—Sir William Osler, 1849-1919, physician, professor of medicine, and author
The Anatomy of Hope

On October 26, 2003, the Southern California Permanente Medical Group (SCPMG) commemorated its 50th anniversary with a celebratory event in Pasadena. In addition to the presentations of a video and a book on SCPMG History, we recognized Dr. Oliver Goldsmith for his ten years as SCPMG’s Medical Director and Dr. Irwin Goldstein for his 22 years as SCPMG’s Associate Medical Director/Physician Manager of Operations.

We planned a keynote address by Dr. Jerome Groopman, Professor of Medicine at Harvard Medical School at the Beth Israel Deaconess Medical Center and a staff writer for The New Yorker magazine in medicine and biology. Unfortunately, Santa Ana winds whipped up brush fires throughout Southern California that weekend, and when the traffic control center for all Southern California was evacuated for almost 24 hours because of the fire, flights in and out of LA were delayed or canceled—including Dr. Groopman’s. By the time he arrived in Los Angeles, it was too late to speak at the 50th Anniversary Celebration, but later that week (upon his return to Boston) he videotaped the remarks he was going to give.

In 1997, Dr. Groopman published his first book entitled: “The Measure of Our Days.” It presented eight moving portraits of patients facing serious illness. He offered his readers a compelling look at what is to be learned when life itself can no longer be taken for granted.

His second book, entitled “Second Opinions,” was about navigating the world of medicine, where knowledge is imperfect, no therapy is without risks, and the outcome is never fully predictable.

His third book, “The Anatomy of Hope,” published in January 2004, was the topic of his remarks to commemorate SCPMG’s 50th anniversary. Both the book and Dr. Groopman’s remarks offer lessons to both patients and health professionals.

— Les Zendle, MD, Past Associate Medical Director, SCPMG

Excerpts from the keynote address prepared for SCPMG’s 50th Anniversary Celebration, October 26, 2003

Physicians, nurses, social workers, psychologists—all of us involved in caring for patients—occupy a unique perch. We are intimate observers of life’s mysteries. We witness the miracle of birth and the defining moment of death. We are close to people who, under extreme circumstances, search for meaning in the midst of suffering.

I’d like to talk about “The Anatomy of Hope.” This work is a mirror to my limits and my shortcomings. It charts a 30-year journey searching for an organizing principle to coalesce around my work and personal life. I realized that as much as my patients search for meaning, I, as their physician, search for meaning.

This project of trying to understand hope came around at the end of a long, very trying week, when I was walking back from the ward to my laboratory, after seeing people with blood diseases and cancer and AIDS. I asked myself what more I could offer these patients whom I had seen that day? The answer that came to my mind was “hope.” And that answer was at once both exhilarating and terrifying.

**Pandora’s Box**

In Maurice Lamm’s book, The Power of Hope, he wrote about his daughter, who had leukemia: “We know in our bones that hope is everything, but in the back of our minds we suspect that it’s nothing at all.” I began to wrestle with this idea of hope’s power and fragility as I read more deeply about it. I came across the myth of Pandora and discovered I did not know the full story. Everyone knows the expression “Opening Pandora’s Box” means you’re releasing troubles into the world by opening something up, sticking your nose where you shouldn’t. But the full myth reflects the deep wisdom of the Greeks.

Pandora was the first mortal woman. Zeus gave her a box. In the box were all human curses, all the troubles that one could imagine, but also all human blessings. She was told not to open the box and, as these stories go, temptation gave way to curiosity. She opened the box and all of the world’s troubles were released and all human blessings escaped and were lost, except for one, Hope—because without hope, the Greeks knew, mortals could not endure.

That myth resonated very, very deeply within me. I realized that this was indeed a revelation to physicians of my generation—but really is not a revelation to those who came a generation or two before. I grew up and was educated in the...
early 1970s, when the molecular revolution was exploding. The pursuit of my career largely followed this pursuit of hard science. I left Harvard to go to the University of California, Los Angeles, because Caltech and UCLA were collaborating around recombinant DNA technology. This was “real, hardcore” medicine. This was science finally entering the domain of clinical work, and it was intoxicating. And, indeed, science is wonderful and is marvelous but it is not the whole story. Far from it. CAT scans and MRI scans came around that time. Now we have gene arrays and proteomic analysis. We can probe so deeply, using crystallography, and obtain an atom-by-atom understanding of the pathogenesis of a disease. Where is hope in all of this? During my training and during my early years of clinical practice, very little attention, if any, was paid to hope. In fact, it was denigrated, seen as soft and squishy. Anyone who would pause and try to talk about the turmoil in a patient’s heart and soul received raised eyebrows, a shrug. The Anatomy of Hope

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Anyone who would pause and try to talk about the turmoil in a patient’s heart and soul received raised eyebrows, a shrug.
for the science, I was pitifully unprepared for the soul. As it turned out, the senior surgeon ultimately convinced her to be treated. How he did this, I don’t know. Such things were not shown to medical students. Conversations of this intimacy occurred behind closed doors, so I never learned how. For a while, this encounter bothered me, but then it drifted from my mind. Only many years later did I begin to think about this. I began to see this woman’s case in more than simply narrow terms. It was easy to just ascribe and dismiss her resistance to treatment as an outgrowth of a fundamentalist theology, where disease is equated with punishment for sin. Only in my fifties, thinking about it more deeply, did I realize that she belonged to that large universe of people who believe that they are undeserving of hope. Her religious background and beliefs were only the particular language, the metaphors, in which hopelessness was cast. I began to realize that hope can only arrive when you recognize that there are real options and that you have genuine choices.

The Core of Medicine

Hope can only flourish when you believe that what you do can bring a future different than the present. To have hope is to acquire the belief that you have some control over your circumstances, that you are no longer entirely at the mercy of forces outside yourself. At the time, as a fourth-year student, I had no insight into any of this. My blindness was sustained for a long time, through internship and residency, where I encountered patients who resisted effective therapy—what I saw as effective therapy—patients who were willing to mortgage their future. I didn’t understand why, and it boiled down to hopelessness.

These patients were dismissed by doctors as being recalcitrant or noncompliant, and they were opaque to me. I did not understand what they were saying to me, and I had no clue what words or actions they needed from me. I don’t mean to minimize this. It is very hard to move someone from a state of hopelessness to hope—to true hope. But, I believe now that movement is imperative and is at the very core of medicine.

Other Forms of Hope

One of the greatest lessons I was taught about hope came from a mentor, a fellow physician named George Griffin, MD. Dr Griffin was from a Yankee family with deep New England roots. He was the chief of pathology in our hospital. This was in the 1980s. I was in my 30s at the time, and Dr Griffin was in his late 50s. He was one of the world’s experts on stomach cancer. No one knew more about stomach cancer than Dr Griffin. And then, I heard he was diagnosed with stomach cancer, a poorly differentiated stomach cancer that had metastasized to the lymph nodes and surrounding tissues of the stomach. Dr Griffin insisted on this extraordinarily aggressive program of chemotherapy and radiation, followed by surgery and then more chemotherapy. As a young oncologist, new to the staff, along with the other young attendings, I thought he was out of his mind or in denial.

But it turned out Dr Griffin was not in denial. He went to the CEO of the hospital and explained that his chances of living 12 months might be on the order of 1% to 3% and that his chances for 18 months were less than 1%. Dr Griffin had even planted daffodil bulbs in his garden at home that he believed would grace his coffin at his funeral. Thirteen years after his diagnosis I was sitting in the atrium café of the hospital and I got up from my chair to greet him. He was retired in New Hampshire with his wife, and it was clear he was cured. He had recovered and was able to contribute actively to his church and community. I had never had the courage to speak to Dr Griffin, but since I had seized on this project to write about hope, I wanted to interview him and to ask how he made his decisions. I also had a deep sense of guilt because, along with virtually the entire young clinical staff, I had written him off. If I had been his managing oncologist and he had followed my advice, he would be dead. So he explained to me his thinking, and he told me that he always knew the odds. There was never a moment of denial or delusion. He knew all the arguments against treatment, but Dr Griffin asserted that it was his right to choose to do what he did. Even if he didn’t prevail, it was his only chance. He deeply, deeply wanted to live, and he told me that this is what impelled him to fight. I realized this was very much a libertarian mindset: he saw himself as an individual who would be the ultimate arbiter of his life. I realized that there are other forms of hope: hope to be strong enough not to yield; hope to have determination and fortitude to fight; hope to muster the will to engage the foe and the strength to sustain the battle. This strong hope, in and of itself, not for everyone but for people like Dr Griffin, becomes a form of victory, because, as he saw it, surrender would be on his terms.

Oliver Wendell Holmes, Sr, an eminent 19th-century Boston physician and poet, wrote “Beware how you take away hope from
another human being.” I think we have this tension to be truthful with our patients but not to snuff out hope. Dr Griffin was truthful with himself, but, he said that a doctor should not sit like a presiding judge who hands down a fixed sentence of life and death measured in days or weeks or months.

**Beating The Odds**

As physicians, we are not omniscient. We don’t know when life will end and death ensue. I’ve come to believe that we should never totally write a person off a priori: because sometimes, as in Dr Griffin’s case, the tumor does not read the textbook. Over the course of some 30 years, I’ve had other patients with “incurable diseases” who beat the odds and lived much longer than anyone predicted. If, for example, I had said to one of them, the mean and median survival for inflammatory breast cancer in your case is “X” months and we have no good treatment for it, that patient would now tell me, “you were wrong and you’re ignorant,” because it has been 20 years since her diagnosis. Her breast cancer comes and goes. I even reviewed the pathology to make sure it was cancer and the diagnosis was correct. But she’s on the far end of the bell-shaped curve. If she had not been given hope, she might not have even tried therapy and she wouldn’t be alive.

The other form of hope in the face of such desperate odds is that science may catch up in time. This event doesn’t happen, alas, as often as all of us pray for. But it has happened in my career with testicular cancer, with AIDS, with the advent of bone marrow transplant, and now with new drugs for lymphoma.

It’s a moving target, and people who literally were on the cusp of death can be brought back.

**Provide Choice and Understanding**

I once hesitated to recount such anecdotes to patients and their families because I feared raising false hopes. Now I believe that if a patient understands his or her own condition and chooses Dr Griffin’s path so that the choices are not made in denial, that patient has every right to hope. It is not as simple as I once thought. I believe that it’s our place, as doctors, to provide choice and understanding to allow for hope, even under the most extreme circumstances. And that is a profoundly human act.

**The Biology of Hope**

I’ll close by talking about the biology of hope. Again, I think that hope is not some magic wand as depicted in those extravagant claims that if you only think positively, it will all go away. There are many, many people who think positively and succumb to illness. But if we look, interestingly, ironically, at the placebo effect, where belief and expectation are cardinal components of the placebo response, we get a glimmer of what might be a biology of hope. Fascinating studies are being done in Italy by Fabrizio Benedetti on pain. These are experiments with normal volunteers. The scientists inflate a blood cuff around the arm and bring it up to 260 mm mercury, which is quite painful, so they have a quantitative painful stimulus. In these experiments, the volunteer is given a very low dose of morphine and, of course, being premedicated with morphine, there is reduction in the amount of pain felt. Then there is a sleight of hand. The researcher gives the volunteer saline, a placebo, but says, “Here’s the drug.” The person has been conditioned to believe he or she is going to receive morphine and, in many people but not in all people, there is markedly reduced pain. This occurs because the placebo effect releases endorphins and enkephalins that diminish the pain response in the brain.

Now pain is one of the greatest stumbling blocks to treatment. Pain is one of the components of the experience of illness that makes it very hard to endure, because pain wears away our resilience. I have come to believe that by instilling true hope, you make it easier for some patients to reduce pain, so they can better endure the vicissitudes of illness and perhaps increase their chances at persisting in beneficial treatment.

Similarly, studies in asthma look at the positive effects of belief and expectation on respiration and the opening of bronchi. And a fascinating study from Vancouver about Parkinson’s disease appeared in *Science*. Patients with moderate Parkinson’s disease were given a drug that released dopamine and, of course, they had more voluntary muscle movement. Then they were given a placebo but they believed they were receiving the true drug. What happened? A large number of patients got better. Their belief and expectation caused the same pathways in the brain to release dopamine. Hope in this way improved them in an objectively measured way.

Very recently, some studies have looked at belief and expectation within the clinical setting, not within the experimental setting. This concept is very complicated, and we should in no way be glib about the results. Ongoing efforts study the experience of illness and the outcome of illness when a physician interacts...
in a hopeful and communicative way with a patient who has heart disease, pulmonary problems, or another malady versus a physician who is acting a role of being terse and noncommunicative and essentially unhopeful. I think it will be fascinating to look at the outcomes of these studies. Earlier studies were done in Israel on the outcome of myocardial infarction. People in these trials who have hope, largely based on faith, have a more rapid and more permanent recovery. On the other hand, I doubt that the studies on remote prayer, where someone is praying in Denver for someone who is in the ICU in Houston and the person in Houston doesn’t know that he or she is being prayed for, will show a remote-control miracle. If this happens, we have to totally rethink the world.

One of the scientists I visited who is trying to deconstruct hope on a biologic basis is an experimental neuropsychologist named Richard Davidson. He’s a child of the 60s, influenced by Norman O Brown. Davidson is a rigorous scientist and sees hope as having two components: one a cognitive component and the other an affective component. To have true hope means to have information in order to think logically about your condition, to see all the pitfalls and all the problems that are in front of you. In this way, true hope differs from optimism. Optimism says everything is going to work out all right. Well, the truth is, everything doesn’t always work out all right. Things sometimes work out very badly. Optimism is a character trait. It is almost a given. Hope is an active emotion. Hope requires meticulously surveying everything in front of you—all the obstacles, all the pitfalls—and finding that path that can bring you to the future. That’s the cognitive part. The second part is the affective part. We talk about wings of hope, being uplifted by hope. There is an energizing feeling that we experience with hope. Davidson is trying to develop experimental methods to assess the physiologic impact of that energizing feeling, of that uplifting sense on cortisol levels, catechol levels, and other important physiologic parameters.

So there is an emerging biology of hope; a number of investigators are pursuing it. This theory is not going to turn out to be magic, but I believe it will find its rightful place in the science of medicine.

There’s a very famous line in the Talmud, the compendium of rabbinic writings about life that says, “Where there is life, there is hope.” What my patients have taught me is that: Where there is hope, there is life. For those who have hope, it may help some to live longer, but it will help all to live better.

Reference

A State of Mind

Hope is a state of mind, not of the world. Hope, in this deep and powerful sense, is not the same as joy that things are going well, or willingness to invest in enterprises that are obviously heading for success, but rather an ability to work for something because it is good.

—Václav Havel, b 1936, Czechoslovakian writer, politician, playwright

Where there is hope, there is life.
a word from the medical directors

The Need for New Capabilities and New Products: One Medical Director’s Perspective

I’m often asked why The Southeast Permanente Medical Group (TSPMG) is among the Permanente Medical Groups in the forefront of the development of “new Kaiser Permanente systems and products.” I will briefly outline our rationale for developing these new capabilities and new products.

I fully understand that the need for these technologies and products is very much driven by the environment in which medical groups operate. Each Permanente Medical Group has its own unique market conditions, history, and circumstances in their regions. My perspectives are driven by the metropolitan Atlanta health care environment, which may differ remarkably from other parts of the country.

In Georgia, our major competitor is dominating the market and devouring a larger and larger market share each year. Other competitors are shrinking, and we, ourselves, are in a stagnate growth mode. My immediate rationale is, therefore, a defensive one to allow us to stay in the Atlanta market. In order to reposition ourselves in this market and remain a viable competitor, we have undergone large-scale organizational change, including the rollout of products with cost-sharing features.

In the national Kaiser Permanente Program, we have called this set of activities “next generation products.” This is a misnomer, because the characteristics of these insurance products were actually defined in the 1970s. These products require new and distinct capabilities. For the Kaiser Foundation Health Plan, the capabilities include, the ability to administer a wider variety of products individualized for major employers; the ability to administer deductibles and other cost-sharing features; and the ability to experience rate these products and to handle the greater complexity of claims and benefit administration.

For TSPMG, these products require the ability to accurately code, bill, and collect as well as to understand the complexities of a wider array of benefit structures that the Health Plan would sell. In a cost-sharing plan, physicians must assist those members as they make complex medical decisions where cost may play a factor.

In Atlanta, we continue to develop, launch, and manage these new products to help us attract higher levels of profitable growth. Although we’ve had success with large employers, we have not been successful in serving small- and medium-size employers, which represent a substantial part of this market. We have developed these capabilities so we may offer two distinct products. One is a three-tiered product that includes:

- Tier One—the core delivery system,
- Tier Two—a leased PPO, and
- Tier Three—a standard Point of Service

This is a total replacement product that is necessary to penetrate the Atlanta small-group market to meet both geographic and choice considerations. The second product is a deductible product, generally in the range of $500-$1000, that is sold to individuals and to some major groups.

In addition, I have led the medical group in developing systems necessary to implement these new products and also enable us to better manage operations across all lines of business. The capabilities of coding, billing, collecting, and assisting with health care decisions those members who are paying out-of-pocket costs for some services, are not only needed for administering new products but also for an array of future circumstances that may confront our medical group, such as emergence of a national single-payer system.

Georgia was one of the first KP Regions to implement the KP HealthConnect systems. Last year, we achieved two important milestones—upgrading our appointment scheduling system, and implementing a new registration and billing system. We will spend much of this year laying the foundation for KP HealthConnect...
Clinicals (the Automated Medical Record and other features). These new systems are certainly revolutionizing the way we conduct business, deliver care, and communicate with each other.

I believe that Permanente physician leaders should be in the forefront of developing these new capabilities. They can assist the Health Plan in developing rational benefit structures that protect our most vulnerable patients. Our leadership can ensure that the plans be easily implemented, both for our patients and for our physicians. Through leadership in developing these products, we can ensure that we are enhancing the skills of our physicians in confronting not only these products but also an entirely different set of services that may be required in the future. We can assist the Health Plan in developing products that build on our unique history, structure, and demonstrated quality and not just follow our competitors.

So for me, I have a clear and present need for the TSPMG to be in the forefront of the development of these capabilities to preserve our wellbeing in Atlanta. Ultimately, I believe we should lead this work because it will be important to our future growth and stability.

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The Undertaking

I am highly enthusiastic over the possibilities to provide prepaid medical care of the highest quality at low cost through a group organized like the Permanente Foundation under the superb direction and honest leadership of Dr Sidney Garfield … Every possible assistance should be given to this undertaking.

—Dr Karl Meyer, Director, Hooper Foundation, University of California, 1945
Permanente Roundtable Discussion

Next-Generation Cost-Sharing Products—
The Concerns, The Experience, The Future

Part 1: The Concerns

Introduction

On October 9, 2003, The Permanente Journal (TPJ) held a roundtable discussion with physician-leaders from six of the Permanente Medical Groups (PMGs) who were present at the National Products and Benefits Development and Implementation Group meeting in Atlanta, Georgia. People involved in this work from Health Plan and the PMGs had gathered there to hear the Georgia Region’s experience implementing next-generation cost-sharing products.

Through reading this roundtable discussion, we hope that you will be able to join the dialogue about cost sharing you may be increasingly having in the next year or two. The Georgia and Colorado regions and Group Health Cooperative have all implemented cost-sharing products. In July, the Kaiser Permanente (KP) Northwest Region will implement these Health Plan benefits which include deductibles, higher co-pays and co-insurance. Members and employer groups will have purchased these plans to lower their monthly premiums to be able to afford KP health care.

There is understandably much concern and anxiety among us about what this will mean for our medical care of patients, our conversations with patients, and how this will integrate with other changes occurring (eg, HealthConnect).

For now, the best we can do is to understand physicians’ concerns, learn from the experiences of other regions, and educate ourselves to have expanded conversations with patients. The Interregional Clinician-Patient Communication Leadership Group (IRCPG) has been at work developing CME workshops on cost-sharing conversations. The Georgia region delivered a revised second version in February.

This roundtable discussion will be presented in two parts to make the information more understandable and accessible for you. The first part will address physician concerns; the second part will review the implementation experience in three regions, and will look to the Health Plan products, service delivery, and Permanente Medicine.

The moderators for this discussion will be Jon Stewart, Director of Communication for The Permanente Federation, and Communications Editor for The Permanente Journal; and myself, Tom Janisse, MD, Assistant Regional Medical Director, Health Plan and Human Resources, Northwest Permanente, anesthesiologist, and Editor-in-Chief of The Permanente Journal.

Participants

Victor Collymore, MD, Medical Director, Care Coordination, Integrated Group Practice, Group Health Cooperative and Medical Director, Group Health Options

Harry Glauber, MD, former Assistant Operations Medical Director for Specialty Care, and endocrinologist, Northwest Permanente

Lee Jacobs, MD, Associate Medical Director for Professional Development, and infectious disease internist, The Southeast Permanente Medical Group

Michael Mustille, MD, Associate Executive Director of External Relations, The Permanente Federation, and occupational medicine physician, The Permanente Medical Group

Jeffrey Selevan, MD, Associate Medical Director, Business Management, and emergency physician, Southern California Permanente Medical Group

William Wright, MD, Associate Medical Director of External Affairs, and former Operations Medical Director for Primary Care, family practice physician, Colorado Permanente Medical Group

Les Zendle, MD, Associate Medical Director, SCPMG (1993-2003), currently internist and geriatrician at the Los Angeles Medical Center, Southern California Permanente Medical Group

The Market Has Become Unaffordable

Dr Wright: Since the decision to implement these new products—and each region is on a timeline to do this, with Georgia first, and then Colorado—I have been talking with physician leaders and with chiefs of departments to understand their views. We have also held several group discussions at the departmental/facility level. In spite of the general sense of concern, I have been approached by physicians who are actually hearing from their patients concerns around affordability. When physicians hear that from their patients, they understand very clearly that we need to do something different, the market has become unaffordable. The physicians who are younger or newer in the group and who have a background in “private practice” are more
attuned to issues of affordability in the way of doing business. The physician who has been with Kaiser Permanente (KP) for many years would be a lot more apprehensive about breaking the mold and may be fearful: Once we crack the dam, what else is going to happen? We have to be sensitive to those fears.

**Dr Zendle:** There’s an understanding of the business case for these products among the leadership—among the SCPMG Board of Directors and some of the Chiefs, but I don’t think it has gotten to the frontline physician. One of the reasons that we’re hearing anxiety is that we don’t have a good track record in KP of planning for how new initiatives on the business side are going to affect clinical practice—preparing physicians, listening to their concerns, and helping them get through the transition. Whether it’s about using encounter coding systems or HEDIS or pharmacy utilization or disability forms or whatever, we didn’t think to work it through with the physicians. Therefore, our physicians are very suspicious that this is just about another change that is going to have an unclear effect on their clinical practice and that they’re going to hear a message that says, “This is no big deal. The market’s making us do this. You’re overreacting.” So I’m very pleased that this initiative seems to be occurring differently. We do appear to be listening to concerns of physicians, and we have an opportunity to teach them why and what and how we’re going to help them and acknowledge that it’s not going to be easy—that it is going to cause change and stress and that we’re going to do everything we can to help them.

**Dr Selevan:** In general, the direct patient care providers—physician and nonphysician—that I’ve talked to about the high-deductible, cost-sharing products that we’re bringing to market uniformly dislike them on first hearing about them and say, “This is contrary to our genetic code.” Then I go through the business case and explain the rationale and put it into the context of the membership losses we’ve experienced; by the end of the discussion, they get it. They understand why we’re losing members to competitors who offer these products. And even though they don’t like it at the end of the discussion any more than they did at the beginning, they’ve a better understanding of why we need to adapt to the market, at least to be able to compete with the hope that at some point this, too, will pass, and that we’ll go back to the comprehensive type of care that we’re used to giving.

**Dr Collymore:** My experience has been that certainly the leadership in Group Health Permanente understands the market forces—understands the whys—but is not enamored with this, doesn’t like it, and regrets it. When you speak to the front line physicians, they will understand the business case after it’s explained to them, but they also say that it is not the Group Health they’ve come to know, love, and understand. And what are we doing as an organization to change this, to change the business environment, so that the employers are not being driven to act in this fashion? That’s the challenge that’s coming back to us. Physicians understand the rationale once it’s explained to them and are willing to adapt, but they’re asking us not to be accepting of the status quo and to move to a different solution.

**Dr Wright:** There is an understanding that there’s a crisis of affordability. There may be less understanding or less acceptance that these products are the right tool to solve that problem. With that being said, if this is not the right tool, and if this is really a bridge to somewhere else, that somewhere else is obviously the delivery of care and how we practice medicine. This leads us to the view being promulgated by folks like the Institute of Healthcare Improvement (IHI) thinkers, that getting rid of waste is ultimately the way to address the affordability problem. Physicians that have been hired recently, two thirds of whom have come from the private sector in the last five years, usually say: “Duh, what’s the big deal?” And I agree that physicians who have been with Permanente longer have been more insulated from the market and from the actual cost of care. They will struggle more from a cultural point of view. We have to keep helping people understand the why, the context, and then allow physicians to have an opportunity for revisiting core values. We emphasize that we are trying to continue delivering our comprehensive benefit package but we are trying to create other doors to access that package. So, yes, we understand the affordability issue but is there agreement about the mechanism to solve the problem? No. Is this a microcosm of the larger issues going on in health care? Yes.

**Potential Membership Losses**

**Dr Jacobs:** Our doctors don’t have the long history that many other Permanente people do around the core value of prepayment, which is the one that’s at stake with these new high-deductible products, and so they don’t hold on to it quite so closely. Our physicians are aware of the market pressures, and they do not feel secure when they look at membership losses in the past year, so I think they definitely have a sense of
need. Their question is, "Is this going to change our care even more in the future?"

Dr Mustille: Part of the anxiety I’m hearing has to do with some misunderstanding of the “what,” as opposed to the “why.” What I hear from physicians is: “What? We’re going to change the organization into Wellpoint? Or Cigna?” And I don’t think that’s the “what” that we’re actually doing. So let me relate an experience I had recently following a meeting of the Care Management Institute network, to which I invited an executive VP of Human Resources from a major national bank. He sat through the meeting and listened to presentations from Paul Wallace, MD, and Jay Crosson, MD, about changes in the insurance aspects of what we’re doing and how we need to adapt with these new products while continuing to pursue excellent quality outcomes and cost efficiency. At the end of the meeting, he leaned over to me and said, “You know, Mike, we don’t want you guys to change what you do.” He said, “What we are asking you to do is find a way to bring KP to more people, not change what you do.” In that context, if we can talk to physicians who are really anxious about changing the organization into something different, if we can talk to them about how what we are doing is not to change the organization into something new but rather to bring what we do well to a broader audience, then they’ll understand that. It sounds a little Pollyanna-ish, but that is actually what the purchasers are asking us to do. And, the way we respond to that, the way we design these products and new benefits, can certainly be a positive way of improving and changing KP, not to mention surviving economically. So I think part of the way we have to answer the concerns of the physicians—which we should not minimize and which are very real—is to show how we’re going to support them in doing what we need to do from the delivery system perspective and show how this can enable KP to actually advance rather than retreat. But we should not foster the concept that we’re going to eventually get back to the good ol’ days in some future glorious state. Rather, this is a part of a transition in which KP is taking its rightful place in American health care.

Dr Zendle: If I can just add to what Mike said, what’s also true is the inverse: If we do not change, if we keep having only the comprehensive products that we have, there will be fewer people who are able to be part of KP or Group Health Cooperative. That gets physicians’ attention because physicians have this sort of ambivalence about growing membership, but they’re not ambivalent about losing members.

My Relationship in the Exam Room

Dr Glauber: One of our values as Permanente physicians is to be evidence based in our clinical and scientific approach. And while we can understand the market forces that are making us make these changes—and to some extent we’re modeling our co-pays and our product design from what the market is doing—I find myself asking questions: We understand there will probably be impact on utilization and we would like to see less inappropriate utilization and, if anything, more appropriate utilization, but what does the literature tell us about the impact on utilization, in our kind of population, or membership, of the kinds of products we’re proposing? And there is scant literature. We need to bring it out and update it and look at it. Very clearly, the first question physicians ask is, “What is this going to do to my relationship in the exam room? Am I going to need to have a fee schedule? Am I going to be negotiating costs with patients? Are they going to be venting their dollar issues, dollar depressions, to me? How am I going to deal with that?” We focus a great deal on member satisfaction, the service aspect of care quality. Are we going to be shooting ourselves in the foot with member satisfaction by changing the way we organize our financing? And what impact is it going to have on individual health? Are people going to decline to take necessary treatments or tests that we prescribe? On an individual level in the exam room, when I say to a patient, you need to do this test and it’s going to cost you $200, will the patient say, “Well, I can’t do it this month, Doc.” But, additionally, at the population level, I’ve spent a lot of energy over the years in population-based care of chronic diseases, things such as diabetes, hypertension, osteoporosis. Much of our energy has been focused on outreach to people who are not seeking care. We’re calling people, saying, “You need to come in and do a hemoglobin A1c test.” Or “You need to go in and get your eye exams.” They don’t want to do it. They don’t perceive the need. We want them to do it for the sake of their health and perhaps for our HEDIS measures or for CMI measures. But now KP wants them to do something that they don’t want...
to do, and they’re going to have to pay more for it. It’s going to be more of an uphill battle to get that to happen.

**Dr Wright:** I would agree with the concerns I’ve heard. But I would rephrase them as time, relationships, and unintended consequences; and, surprisingly, I’ve even heard docs expressing actuarial concerns. With regard to time, it’s just that there’s so many “initiatives” colliding in the exam room while we have this movement toward cost-sharing products and we’ve got all the implications of HIPAA, deployment of the automated medical record, more emphasis on correct coding, and, in our region, the launching of a new hospital and multispecialty facility. Somewhere in the middle of all that, you’re supposed to actually deliver care and have a relationship with patients.

It’s probably self-explanatory that this is our culture—folks want to come here and practice medicine without having to think about “that stuff”—unintended consequences—I’ve already begun to hear about the possible unintended consequences of short-term gain and long-term adverse impacts. For example, a patient tells you, “You’ll have to put me in the hospital to do that test because I don’t want to pay for it as an outpatient.” The last category is the actuarial concerns. The concern has been around trying to understand the phenomenon called “profit by line of business.” You know, basically, are we going to offer this product to the right people? You could err on both sides, both extremes. I’m not an insurance expert, but let’s say you offer one of these lower-premium packages to people who aren’t likely to leave the program anyway, and so now you’re just getting less in premiums. On the flip side, there’s that category of patients who are excessive utilizers, that 5% of the population using about 50% of the care. A lot of people I’ve talked to think those patients will blow through their out-of-pocket maximum by the middle of January, and then we’re on the hook for the rest. So there’s a lot of anxiety about whether we can actually do this successfully.

**Permanente Values**

**Dr Jacobs:** The concern in Georgia has fallen into three areas. One is Permanente values, meaning, does this go against who I am as a Permanente physician? Does it go against my values? And collectively, as a medical group, is this really what we’re in Permanente for? The second concern is introducing the cost barrier into patient communication. And the last theme that we heard about was the risk area—whether it’s around adherence or just putting up another barrier to care. There’s a fourth area that we’ve heard about in Georgia that involves delivering great service, including compassionate care. There’s a sense that maybe this is not such compassionate care, and that’s a mindset we’re going to have to deal with to make sure that there is a compassionate approach to administering these new products.

**Dr Collymore:** Another concern I hear is: Are we part of the solution or part of the problem? Is this phenomenon contributing to a societal problem by putting comprehensive care out of the reach of people who need it most? On the flip side, though, some physicians are also saying that this may offer a potential opportunity to align patients’ behavior with our care management strategies or to make sure that the EDs are used appropriately or that appropriate pharmaceuticals are selected. So there may be some positives here that physicians are seeing.

**Dr Mustille:** I agree with that, Victor. There are some positive aspects to it. One other thing that has come out in conversations with physicians is the issue of medical/legal liability—physicians being concerned that somehow they will be held responsible from a legal perspective when outcomes don’t match their expectations, because of care that was either refused or deferred. The solution is for everyone to know what the physicians need, as far as understanding their legal responsibilities and ethical responsibilities, to help defuse some of that concern.

**Dr Selevan:** There’s another concern I’ve heard that’s not related to clinical care but more to service. I’m fearful that when our members have a high deductible product and have to wait for what they perceive is an inordinate amount of time for a procedure like colonoscopy and have to pay for the full value of that procedure, they’re going to confront the physician with, “Well, I could’ve gone across the street to a local doctor for the same amount of money; What value am I getting from KP?” It’s going to put our physicians into a very awkward situation. They’re going to have to deal with a different type of patient interaction than they have had to face in the past, when the patients’ financial liability was limited to a modest co-pay.

**How PMGs Are Addressing Physicians’ Concerns**

**Dr Jacobs:** We are at the very early stages of addressing the needs that you all stated so well. It’s certainly something that’s not done overnight. What we’ve realized as a group is that we’ve got to start at the very basic cultural level, at the level of values, and what’s not going to change. That’s been a good exercise for us. We
talked about the role of the physician in the exam room with these new products, trying to be really explicit, really clear about what might happen. And we talked about the role of the people around the physician, such as the billing office staff and the changes taking place there. We try to emphasize that, in fact, the business office is going to be very different with an expanded role. So we’re dealing first with these cultural issues. Second, we’ve developed opportunities for physicians to participate in CME workshops that can help them get a handle on some of the new patient communication barriers. We’re giving people a lot of skills in how to handle the conversations and, at the same time, are making them aware of the business processes. But we have a long way to go, and we’re going to need everyone’s help. I think it’s going to require a Permanente-wide solution to do this; it’s not a Georgia issue alone. We’re trying to make it truly interregional by working with other regions.

Dr Wright: The PMGs, as leaders and partners with the Health Plan, absolutely cannot stick their heads in the sand on this issue. We need to be very clear to our medical groups that we are at the table and that we are fully functioning as partners with the Health Plan in looking at these issues and that we’re committed to learning about these issues, what’s going on in the market, etc. We also need to be very clear that we are committed advocates for the individual patient in the exam room, as well as for taking care of our community of patients. The other commitment we need to make to our physician groups is that we will be quick learners and that we will modify as we go and will give feedback. We in Colorado have consulted with two groups. As you know, most of the regions have these clinician-patient communication folks, and we’re working with them in terms of creating scenarios that actually give people a chance to think through various scenarios. We’ve also discussed these products with our bioethics committee. Their feedback around potential members being fully informed about what they are purchasing was valuable. We’re also trying to educate folks about the market and what drives the cost of care, because a lot of physicians have been very insulated from the cost of care.

Dr Collymore: Sometimes the environment you’re working in affects how folks respond to these products. Washington State has the second highest unemployment. I think, just after Oregon. Given that environment, where membership losses have been forecast, the receptivity to cost sharing is enhanced. In July, the Group Health Permanente physicians for the first time had to start sharing in premium costs themselves. This was not exactly greeted enthusiastically by the front-line physicians, but nevertheless the argument can be made: How can we offer products that are asking for cost sharing from major employer groups if we’re not willing to participate in the same cost sharing. These types of examples have made it a little bit easier for our folks to understand the current realities.

On Exam Room Conversations About Cost

Dr Jacobs: There will be a very different kind of conversation with patients in the exam room—conversations about cost. And the onus on the leadership of the medical groups is to support that conversation. Much of our care in Georgia is provided by nurse practitioners and physician assistants, so we want to make sure they have opportunities to really enhance that skill. And I believe it is a skill, and it’s one that not all of us have. The physicians coming from the community clearly have the knack, but many physicians choose to avoid the conversation. It’s like the traditional death-and-dying discussion—everybody agrees it’s important, but we don’t do it. So the onus is on the leadership of the medical groups to support the physicians’ conversations, and some will have an easier time than others. Also, it’s the responsibility of the entire organization to support that conversation in the exam room. It’s going to be a major challenge for us because it is so huge and there are so many complexities to make it work right. But if it’s done right, it shouldn’t affect care, except possibly in a positive way. I honestly believe that the idea of involving the patients in decisions about their care, whether it’s drugs, lab tests, or what-have-you, is positive. The more we engage the patient, the better we are. This is a major opportunity.

Dr Zendle: I agree with Lee, but I also think there are certain conversations that aren’t appropriate to take place in the doctor’s office. If we expect our physicians to become experts on benefits financing, then we haven’t supported them like we need to do. Yes, it’s going to change the conversation between doctor and patient, and we need to help our physicians with the skills to change it in a positive way. We also need to make sure that we’re not leaving the physicians hanging in the wind by expecting them to have conversations that really

Part 1: The Concerns

Dr Glauber: Yes, we need to have a very explicit safety valve in the exam room for the clinician to be able to say, “I understand. Here’s who you can talk to in the office.” And they need to be available. And patients shouldn’t have to be on hold for an hour, getting angry, waiting to talk to them. We don’t have the next-generation products yet, but these conversations are already happening. Part of my strategy with patients with diabetes was to simplify the visit by asking them up front, “Well, what’s your agenda today?” So we’re not guessing. Just a few weeks ago, a patient pulled out an ad from Parade magazine, wanting the newest brand of insulin, which unit for unit is about four times the cost of the alternative. Clinically, it was not unreasonable, so I was prepared to prescribe it for him. He went down to the pharmacy and came back up 10 minutes later very unhappy, saying he couldn’t pay for it. So I had to go back and rewrite my instructions.

Dr Jacobs: That’s a good example—the patient wanted the newest-brand insulin but then didn’t want to pay four times the cost of the alternative. Now the patient’s prepared to engage with you and he’s going to be involved in the decision. Was the incremental benefit of this new insulin really worth the additional expense to that member? That’s a joint decision you two can make.

Dr Glauber: It’s not all negative, because if it’s something that’s critically necessary, you say, “You have to take this treatment. There is no alternative. That’s the reality.” But for so many things that are patient-driven, there is a marginal incremental benefit. You get an added degree of certainty by doing the CT scan, even though it’s probably going to be normal. Once the patient realizes the cost of it, we won’t have to deal with a lot of what is discretionary—such as the very expensive antibiotic or the very expensive PPI instead of an over-the-counter H₂ blocker, which would work just about as well. So, we will see some benefits in more rational care.

Dr Mustille: We may actually see better care, because we’re taking the patient’s perspective on value into account in a way that we did not have to do so explicitly in the past. Let me give you an example of how, in my own practice, which is occupational medicine, we have a similar kind of challenge. A few years back, we realized that physicians were not managing disability very well in occupational health. The reason was that, just as with cost issues, disability wasn’t being discussed. Physicians and patients were both avoiding the conversation about disability. We took the time to focus on that and to train physicians to make the disability conversation an integral part of care planning just as perhaps we ought to be making resource efficiency part of the value structure in which patients make decisions. And guess what? It turned out that not only do we manage disability better, we also get people better faster because the disability conversation was part of the treatment plan. People actually got healthier faster, went back to work, and ultimately had less permanent disability. Now, obviously the parallel doesn’t work perfectly, but it’s an opportunity for shared decision making that actually turned into a win-win situation. There’s the potential for this same kind of conversation to happen with resource efficiency.

Dr Wright: Interestingly, when we were looking at some data about employers’ concerns about health care costs, we noticed there had been a slight down tick from about 2000 to 2001; a little less anxiety. When I dug into that statistic a little bit more, I found that a lot of employers feel they have found an answer with cost sharing. There’s a belief, right or wrong, that now that patients are going to be a little more engaged about costs, they’re going to be back in the exam room asking questions that perhaps they weren’t asking before. I can’t say that that’s totally negative.

Dr Collymore: In the old way of doing things, if a physician decided not to give patients what they wanted for clinical reasons, the doctor was in the position of being the bad guy. Now it can be out in the open. When the doctor says, “I don’t really think you need this.” The patient says, “Well, it’s gonna cost me $100. If you don’t think I really need it, maybe we won’t have it, doc.” And, the physician will be removed from being the bad guy.

Dr Janisse: Do you think that introducing new cost-sharing products can lead to preventive medicine, or self care, on the part of the patient?

Dr Wright: We are designing our benefits to still show our bias towards preventive care (for example, zero-dollar co-pays for some prevention visits). Other feedback from some physicians regarding cost sharing and the decisions in the exam room, show a sense that since quality is often defined as choice in America, we should provide options for patients to “buy up.” For example, a bone mineral density study, it may not be indicated, they’re not in a high-risk group but their neighbor got it, and they want one, and, for extra cash, can they have that? Or, screening colonoscopy might be another example. So, from a consumer-demand point
of view, they would be able to purchase it, adding an aspect of choice in their care.

**Dr Zendle:** However, we’ve trained our physicians to think about medical necessity. It’s **either necessary or it’s not necessary.** And there are some problems with what you just suggested, especially within the regulatory environment we’re in now, in that if it’s necessary, why are you charging me more for it? And if it’s not necessary, then why are you offering it?

**Dr Mustille:** There isn’t too much literature on the relation of cost sharing to preventive care and necessary care. But as you know, the Rand studies have shown, unfortunately, that when you put in financial barriers to care, necessary care suffers as well as unnecessary care, and almost equally, so that patients defer or avoid care that is recommended or necessary just as they avoid care that is truly discretionary. When we think about why, maybe it’s that patients don’t know which is which. They don’t know which care they really need (ie, that is worth paying for), versus that which appears to be just as important. But on a scientific basis, the care may truly be discretionary and not needed. One of the advantages that we may be able to find in this discussion of resource effectiveness is to be able to help patients distinguish between what’s worth spending money on and what is not worth spending money on and in a way, to help them know how not to defer care that is critically important to get the best outcomes.

**Dr Collymore:** Well, besides preventive care, one thing that will align the incentives, as we are doing in Group Health Permanente, is putting in an electronic medical record with secure messaging. With office visit co-pays going up and co-insurance coming in, and with the advantages of technology, patients may not have to come in for a URI, for example. They can talk to their doctor electronically and have their needs met. So this may be an advantage where, with technology and cost sharing, it will drive the member into the appropriate method and venue of care.

**Dr Glauber:** We are also introducing secure messaging right now, and the physicians are expressing the fear that we are going to do more and more of that. It’s not in the base schedule. It’s sort of between the cracks at lunchtime or at the end of the day. Physicians’ worry, “I’m doing all this extra work that I’m not being paid for.”

Thank you. The discussions about the implementation experience in three regions and thoughts about the future (Part II) will appear in the next issue of *The Permanente Journal.*

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How Much You Care

Patients don’t care how much you know until they know how much you care.

—Jill Steinbruegge, MD, PMG Federation, and Robert Sachs, PhD, at the Advanced Leadership Program, University of North Carolina, 1998
Colorado’s *KP Helps* Assists Patients In Need

In response to rising copays for health care, Kaiser Permanente (KP) Colorado has greatly expanded a 13-year-old charitable fund to assist low-income members with out-of-pocket expenses not covered by their benefit plan.

Called *KP Helps*, the program has traditionally been funded by contributions from individual Kaiser Foundation Health Plan employees and Permanente physicians. In December 2002, in response to concerns about increasing copays, the physicians of the Colorado Permanente Medical Group directed $500,000 of their money as a donation to *KP Helps*. The contribution was funded by transferring to *KP Helps* $1000 from the 2002 variable deferred compensation of each eligible physician. This contribution will be used over three years. The Health Plan also contributed $150,000 as matching funds to staff donations.

KP members experiencing financial hardship are referred to *KP Helps* by KP staff and physicians. Applicants are then screened for financial need. Members qualify for *KP Helps* if their income is below 200% of the poverty level or if their health care costs are more than 20% of their income. Liquid assets must be less than $4000, excluding a retirement account.

Awards are capped at $400 and can be used only to cover health care costs, not premiums. The most frequent use of awards is to help pay for pharmaceutical products. Other frequent use is for durable medical equipment, visit copays, and medical procedure copays for MRIs, CTs and colonoscopies. The highest utilizers of the fund are persons with chronic diseases, including diabetes, heart disease, asthma, psychiatric disorders, pediatric diseases, and pregnancy-related issues.

The expansion of *KP Helps* was motivated in large measure by growing concern that copays, when applied to lower income members, may restrict use of both essential and nonessential services. This in turn may lead to poorer clinical outcomes and higher downstream treatment costs for preventable disease states.

A recent study published in *JAMA* investigated this issue. The study found that after cost sharing was introduced or among poor and elderly persons. Importantly, there was no increase in emergency room visits or adverse events in those who did not decrease their use of essential drugs after the cost-sharing was introduced or among those that decreased their use of only non-essential drugs.

Given current economic realities, *KP Helps* will be faced with significant future challenges. The use of *KP Helps* more than tripled from 2000 to 2002, and 2003 data indicated this trend will continue.

The rising cost of medical care will continue to vex both providers and consumers of health care. The challenge for KP will be to compete effectively in the marketplace while providing the highest quality care possible to all its members. Programs like *KP Helps* can be a part of the answer to this challenge.

Reference

A Patient’s Manifesto—Communicating in the Exam Room

Introduction
There is much debate and finger-pointing as to who is to blame for the present crisis over the financing of health care. Blame is assigned to every entity involved in the process of care and, truth be told, they all probably have a level of accountability for the crisis. However, there is very little focus on what we all would have to agree is a major contributor—the consumer making purchasing decisions is not paying the bill. No wonder health care costs have spiraled out of control! The patient-consumer is given a blank check and interacts with a provider-seller of the product who has few if any incentives to provide the most cost-effective quality product. Why, then, are we surprised that, in attempting to appease the consumer over the years, the provider has given away the store? The present financing system for health care is providing the exact outcome for which it was designed.

Change is needed. If significant and effective steps to revise the process of paying for care are not implemented, the Federal government will take over the store. A different payer, but the same lack of accountability on the part of the consumer and the provider.

As we all are aware, the present-day solution is to have the consumers of health care shoulder a portion of the financing of their health care cost. The intended result is that not only will the primary payer’s bill be less, but it is also hoped that the patient will be much more involved in decisions related to choices in their health care experience. Easy to state, but what might patient involvement actually look like?

For a patient’s involvement in decisions to be meaningful, the clinician and patient will need to have a drastically different conversation if our society is to take the necessary major strides to decrease the cost of health care. The key word is different, because the type of conversation proposed here is generally not taking place in exam rooms across the nation.

Here are five clinician-patient communication principles that I am calling “A Patient’s Manifesto” (Table 1).

“Doctor, when you are spending my hard-earned dollar, I need you to keep the following in mind.”

Principle #1 - Please Listen
“I want to trust you with my health—and that’s a big step for me. Please hear me out because my trust is based on a belief that you know me well—what I like and what my needs are. This includes my financial capability.”

Principle #2 - Let’s Talk Cost
“Don’t assume I can pay. Ask me! I may not feel comfortable raising the issue of cost each time, so can you please make certain that you bring up cost considerations for medications or procedures? If we don’t talk about what I can afford, I may not be able to follow your directions—and then where will I be?”

Principle #3 - Do What’s Right
“I would like you to ignore what you hear and read from drug company advertisements. Please use your expertise—what you have studied and concluded based on

Table 1. A Patient’s Manifesto

<table>
<thead>
<tr>
<th>Five Communication Principles</th>
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<tbody>
<tr>
<td>1. Please Listen</td>
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<tr>
<td>2. Let’s Talk Cost</td>
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<tr>
<td>3. Do What’s Right</td>
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<tr>
<td>4. I Need to Hear My Options</td>
</tr>
<tr>
<td>5. Please Be There for Me Tomorrow</td>
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</table>

Lee Jacobs, MD, joined the Hawaii Permanente Medical Group in 1980 as an infectious disease consultant. In 1985, he moved to Atlanta to assist in starting The Southeast Permanente Medical Group and still resides there as the Medical Group’s Associate Medical Director for Professional Development and as an infectious disease consultant. E-mail: lee.jacobs@kp.org.
the best available information—and offer that to me. I want the most inexpensive option that you believe will most likely resolve my problem. If I don’t need that expensive blue pill I see advertised, please don’t give it to me!”

**Principle #4 – I Need To Hear My Options**

“When it comes to planning the best next steps for me, please give me options. I come to you because you are the expert. However, it is my choice, and so I want to make an informed decision. With your help, I can weigh what’s best at the very best cost possible. I just need to hear options.”

**Principle #5 – Please Be There for Me Tomorrow**

“Finally, and most importantly, I need you to give me a feeling that no matter what options I choose or what happens, you will be there for me tomorrow if I need you.”

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**Conclusion**

What do you think? Would this be a different dialogue for you to have with your patients? The cost component of the conversation may be new to many physicians, although in reality it is just another dimension for us to consider as we get to know and care for the total patient. I believe these five principles underscore the basics of good clinician-patient communication: listen, help the patient feel comfortable in voicing their wants and needs, present choices so they can make an informed decision, and then remind them that you care about them and will be there for them tomorrow.

Although the clinician may be caring for a patient in an environment quite different from even 10 years ago, the fundamentals of good clinician-patient communication remain the same.

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**Challenging The Process**

A leader who challenges the process is one who seeks a challenge; keeps current; initiates experiments; looks for ways to improve; asks “What can we learn?” and/or lets others take risks.

—The Leadership Challenge, J Kouzes and B Posner, Jossey-Bass
Abstract

Context: Data collected in 1998 on primary physician performance, including Health Plan Employer Data and Information Set (HEDIS) measures, were the basis of reports distributed quarterly to 194 primary care physicians at 25 medical centers in Group Health Cooperative. Here, we summarize results of research designed to assess reliability of measures of physician performance and to identify practice components which influence patient outcome. Various aspects of these results are published in Medical Care, The Journal of General Internal Medicine, and Family Medicine.

Design: Summary of results from studies that used retrospective analysis of administrative data on physician performance measures and practice structures.

Main Outcome Measures: Twenty-three HEDIS measures of physician performance, both individual and grouped into aggregate measures: cancer screening, diabetic management, patient satisfaction, and ambulatory costs.

Analysis: Bivariate and sequential sets of multiple regression models controlled for selected patient panel and physician characteristics.

Results: Although individual HEDIS measures were reliable when used to assess physician performance, aggregated measures were more reliable. Physician continuity was not associated with patient outcome, but practice coordination (measured by shared practice, years of team tenure, and medical clinic size) was significantly associated with improvement in cancer screening, diabetic management, and patient satisfaction. Performance assessment of physicians with reduced appointment hours or part-time status was associated with improved cancer screening and diabetic management.

Conclusions: Assessing physician performance data on individuals yielded useful collective clinical practice information. Analyzing physician performance data collectively can identify effective primary care practice structures and processes and benefit patient care.

Introduction

The Group Health Cooperative of Puget Sound (Group Health) comprises medical centers and networked physician practices in the State of Washington and selected counties in northern Idaho; Group Health Permanente (GHP) physicians work in these medical centers. From 1997 through 1998, GHP primary care physicians received quarterly reports of data collected on their performance. The physicians were working toward improved practice. However, results from practice and performance measures continued to vary widely within and between the 25 medical centers. The Associate Medical Director for Quality and Research and Director of the Sandy MacColl Institute for Health Care Improvement agreed to sponsor a doctoral student to assess the data and its value to improving primary care practice. The objectives were to evaluate reliability of current performance assessment measures and to determine if aggregation of these measures of physician performance was appropriate, to identify components or structures of physician practice that influence patient outcomes, and to extract ideas for practice improvement from the results of this research.

The collaboration yielded new insights into physician performance assessment and practice structures, and articles on different aspects of the research were published in Medical Care, The Journal of General Internal Medicine, and Family Practice. Here we summarize the published research and results.

Methods

Interviews with 30 key physicians and administrators generated the following research questions, which guided the type of data collected and the data analyses.

1. Are selected Health Plan Employer Data and Information Set (HEDIS) measures, which were developed to assess health plans, reliable when used to assess primary care physician performance?
2. Are cancer screening, diabetic management, patient...
satisfaction, and ambulatory costs reasonable and reliable aggregate measures of physician performance?

3. If primary care physicians spend fewer hours in direct patient care, do patient outcomes—particularly patient satisfaction—suffer?

4. Does continuity of care with the primary care physician influence patient outcome?

5. Are specific practice structures beneficial to patient outcome?

Setting, Study Design, and Data Collected

The study population was all 194 GHP family practitioners and general internists who provided ambulatory primary care services for at least nine months during 1998 to a designated patient panel from 320,000 adult Group Health members at 25 medical centers in western Washington. Physicians who provided urgent care exclusively were excluded. The centers varied in size and complexity, but all provided primary care, radiology, laboratory, pharmacy, and business services, and some provided specialty services.

The cross-sectional research design used existing administrative data integrated with additional practice and physician data that we collected. Quarterly reports distributed by the medical group to the physicians for two years before this study included measures of individual physician performance, appointment access, panel size and composition, and patient case-mix. Additional data included physicians’ board certification, validation for specialty, and gender (all obtained from medical directories and from the American Medical Association Web site), and practice structure data gathered from the Human Resources department and practice leaders. These data were merged with the performance data using a random identifier to protect physician confidentiality.

This research was approved by the Institutional Review Board associated with Group Health and its research center. Funding sources placed no constraints upon this research, and Group Health allowed the researcher access to the organization and its data without determining the topic of inquiry, its analysis, or interpretation.

Physician Performance Measures

Performance measures that are systematically collected at the physician level are also considered as outcomes for the physicians’ patient panels. Selected measures were grouped to form the following four aggregate measures of performance: diabetic management, cancer screening for women, patient satisfaction, and ambulatory costs (Table 1). Ambulatory cost measures were averaged for the year, and other component performance data were reported as a rolling average of the previous year. Higher rates correspond to better outcomes for cancer screening, diabetic management compliance, and patient satisfaction, whereas the preferred cost outcome is lower. These measures are widely used, have sufficient patient populations to provide reliable assessment, and represent different aspects of care. For cancer screening, which combines rates of screening in different subpopulations, the aggregate measure is the mean of component measures.

<table>
<thead>
<tr>
<th>Aggregate and component measures</th>
<th>Result (range)</th>
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<tbody>
<tr>
<td><strong>Patient satisfaction</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Percentage “excellent” responses</td>
</tr>
<tr>
<td>Friendliness and caring</td>
<td>14-80</td>
</tr>
<tr>
<td>Attention paid</td>
<td>20-79</td>
</tr>
<tr>
<td>Opportunity to ask questions</td>
<td>20-71</td>
</tr>
<tr>
<td>Explanations given about care</td>
<td>10-68</td>
</tr>
<tr>
<td>Support on ways to stay healthy</td>
<td>14-63</td>
</tr>
<tr>
<td>Time spent</td>
<td>10-54</td>
</tr>
<tr>
<td>Thoroughness and competence</td>
<td>17-76</td>
</tr>
<tr>
<td>Aggregate mean, 42%</td>
<td>17-67</td>
</tr>
<tr>
<td><strong>Diabetic management</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Percentage tested</td>
</tr>
<tr>
<td>Annual foot examination</td>
<td>11-100</td>
</tr>
<tr>
<td>Annual retinal examination</td>
<td>36-90</td>
</tr>
<tr>
<td>Microalbuminuria testing</td>
<td>50-100</td>
</tr>
<tr>
<td>Hemoglobin A&lt;sub&gt;1c&lt;/sub&gt; testing</td>
<td>68-100</td>
</tr>
<tr>
<td>Aggregate mean, 81%</td>
<td>54-99</td>
</tr>
<tr>
<td><strong>Cancer screening for women</strong></td>
<td>Percentage tested</td>
</tr>
<tr>
<td>Mammography, age 52-64 years</td>
<td>53-92</td>
</tr>
<tr>
<td>Papinicolou test, age 21-64 years</td>
<td>53-88</td>
</tr>
<tr>
<td>Aggregate mean, 76%</td>
<td>62-87</td>
</tr>
<tr>
<td><strong>Ambulatory costs</strong>&lt;sup&gt;c&lt;/sup&gt;</td>
<td>$ per member per month</td>
</tr>
<tr>
<td>Primary care, Medicare</td>
<td>36-78</td>
</tr>
<tr>
<td>Primary care, non-Medicare</td>
<td>21-46</td>
</tr>
<tr>
<td>Special care, Medicare</td>
<td>37-145</td>
</tr>
<tr>
<td>Special care, non-Medicare</td>
<td>11-39</td>
</tr>
<tr>
<td>Radiology, Medicare</td>
<td>2-20</td>
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<tr>
<td>Radiology, non-Medicare</td>
<td>2-8</td>
</tr>
<tr>
<td>Laboratory, Medicare</td>
<td>3-12</td>
</tr>
<tr>
<td>Laboratory, non-Medicare</td>
<td>1-6</td>
</tr>
<tr>
<td>Pharmacy, Medicare</td>
<td>22-87</td>
</tr>
<tr>
<td>Pharmacy, non-Medicare</td>
<td>11-56</td>
</tr>
<tr>
<td>Aggregate mean, $85</td>
<td>62-128</td>
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<sup>a</sup> Measured on patient survey.
<sup>b</sup> n = 176
both of which summarize comparable screening rates for subgroups of each patient panel. Assuming a direct relationship between physician services and patient outcomes, these aggregate measures are indicators of both physician performance and the cumulative quality of care received by their patients. The measures of clinical processes, which included preventive services and disease treatment, and outcome measures, which included patient satisfaction, are included in HEDIS measures required of managed care organizations. Furthermore, the cost measure is consistent with National Committee on Quality Assurance report card requirements.

Independent Predictors of Patient Outcomes

The independent predictors of physician performance were hours of direct patient care, continuity of care, and practice structure. Physicians were considered full-time by Group Health Permanente if they had ten appointment sessions (35 hours) scheduled for patient appointments each week; physicians with fewer sessions were considered part-time. Three sessions per week were the fewest a primary care physician could work and have a designated patient panel and therefore be included in this research. Physician direct patient care hours were determined by scheduled appointment hours, which ranged from 10 to 35 hours per week. Clinician continuity was determined by the percentage of primary care physician visits to total physician visits in one year. Practice coordination was assessed through the following three practice structures: shared practice, where two or three physicians accept joint responsibility for patients; clinical team tenure, defined as the number of years each physician worked with most physicians in the team; and medical clinic size, defined by number of physicians.

Statistical Analyses

Sequences of ordinary-least-squares regression equations and comparisons by rank were used to assess physician performance and to determine practice influences on performance. Figure 1 shows the model of practice variables assessed for influence on physician performance measures as well as patient and physician characteristics controlled for in the analysis. The physician performance (patient outcome) analysis controlled for characteristics of physicians (administrative role, gender, seniority) and their patient panels (size, chronic disease score, gender, and age). Of the seven characteristics of physicians and their patient panels, five were significantly associated with one or two patient outcomes and were therefore necessary control variables.

Results

Wide Practice Variation for Each Performance Measure

The data had sufficient variation and number of cases to yield statistically significant results. Figure 2 shows the variation in aggregated measures of performance:

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**Figure 1. Model of the statistical analysis used to determine influence of practice variables on aggregated measures of physician performance**

**Practice variables**

- **Clinician continuity**
  - Percentage of patient visits to the primary care physician (versus any other physician)

- **Practice coordination**
  - Shared practice
  - Clinic size (number of physicians)
  - Team tenure (years each physician worked with other team physicians)

- **Physician hours**
  - Proportion of full-time equivalent (FTE) hours spent in direct patient care

**Aggregate performance measures**

- Cancer screening
- Diabetic management
- Patient satisfaction
- Ambulatory costs

**Control characteristics**

**Patient panel**
- Size
- Case-mix
- Percentage of female patients
- Age

**Physician**
- Gender
- Administrative FTE
- Professional seniority

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Patient panel size calculated by dividing the number of patients in each physician’s panel by the full-time equivalent (FTE) hours the physician is scheduled for clinical appointments. 1 FTE = 35 hours per week. Case mix calculated by using the chronic disease score (determined by prescription data), percentage of females in patient panel, and mean age of patients in panel.
The percentage of patient satisfaction surveys returned with a response of “excellent” ranged from 17% to 67%; the percentage of patients who received appropriate tests for management of diabetes ranged from 54% to 99%; the percentage of eligible women who were screened for cancer ranged from 62% to 87%; and ambulatory costs per member per month ranged from $62 to $128.

**Physicians’ Performance Varies by Measure**

Are selected HEDIS measures, which were developed to assess health plans, reliable when used to assess primary care physician performance? Perhaps—if the physician’s practice is large enough (eg, contains enough diabetic patients) and the measures are used independently.

Are cancer screening, diabetic management, patient satisfaction, and ambulatory costs reasonable and reliable aggregate measures of physician performance? Yes, when the aggregate measures are each evaluated, and performance is evaluated for groups of physicians rather than individual physician performance.

Each aggregate measure was reliable and independent, but loosely predictive, of the others. Each aggregate measure was significantly correlated with one or two of the other measures; high cancer screening rates correlated with close diabetic management and with high patient satisfaction scores; high diabetic management rates correlated with high cancer screening rates; and high patient satisfaction scores correlated with high cancer screening rates and high ambulatory costs. Further, physician performance was inconsistent across aggregate measures. More than 70% of the physicians ranked in the top third for at least one measure, but 80% of these same physicians ranked in the lowest third for a different measure. Sixty percent of the physicians ranked in the top third for one measure and in the bottom third for another.

"Assessments of individual physicians with current performance measures may identify areas in which improvement is needed and facilitate provision of feedback to improve performance quality and efficiency. However, these performance measures, singly or as a unit, should be used cautiously to select, motivate, and reward physicians, or to encourage consumer assessment. There are relationships among physician performances in cancer screening, diabetes management, patient satisfaction and ambulatory costs. However these relationships are inconsistent across all physicians and unreliable for individual physicians."

**Part-time Practice Performance Not Worse**

If primary care physicians spend fewer hours in direct patient care, are reduced hours associated with reduced patient outcomes—particularly patient satisfaction? No. Of the 194 physicians, 39% were considered employed full time by GHP, but because of other administrative duties, 85% of these full-time physicians worked less than full time in direct patient care (Figure 3). Physicians’ direct patient care hours showed a bimodal distribution: 4% worked less than half time (the commitment required for fringe benefits); 30% worked half time; and 20% worked full time in direct patient care.

After adjusting for potential confounders, our analysis showed that as physician direct patient care hours decreased by 10%, the rate of cancer screening for women increased by 0.7% ($p = .010$), and the rate of diabetic management increased by 1.1% ($p = .008$). No association existed between physician direct patient care hours and patient satisfaction ($p = .212$) or ambulatory costs ($p = .323$). Although the data supported the analysis of continuous data at a minimum of three FTE (ten hours), no “threshold” of performance was found.
Physician Continuity Not Related to Outcomes

Does continuity of care with the primary care physician influence patient outcomes? No. Physician continuity was not significantly associated with any patient outcome measure.2

Practice Structures Coordinate and Improve Care

Are specific practice structures beneficial to patient outcome? Yes. Each of the three practice structures was positively associated with some performance measures, and team tenure was strongly associated with all four outcome measures.2 Aspects of practice coordination, as represented by three practice structures (shared practice, medical clinic size, and team tenure), were significantly and positively associated with cancer screening, diabetic management, or patient satisfaction but were not associated with ambulatory costs. Patient and physician characteristics had a large impact on costs. Both shared practice and larger medical clinic size were associated with a higher rate of cancer screening (p < .001) and with better diabetic management (p < .01). Physicians in shared practices were 7% more likely to screen patients for cancer and to better manage diabetic patients. No practice coordination variable, however, was significantly related to either patient satisfaction rating or to ambulatory costs.2

Discussion

Two of our objectives involved testing HEDIS measures for reliability when used to assess physician performance. We found that each individual measure was reliable over time and that reliability increased when individual measures were grouped with correlated measures into four aggregate measures. However, physician performance was not consistent across measures, a finding that was also reported recently in Boston area clinics.10 Although some specific measures are significantly related, overall predictive value of any single measure is low. The aggregate performance measures appear to assess different aspects of practice; therefore, blending their results may mislead to conclusions. “Because these aggregate measures are not strongly correlated, an overall measure, or using [one] as a proxy for all, is not recommended. Care should be taken in assessing physicians based on narrow performance measures resulting from current inconsistency in performance and the evolution of quality measures.”1

Our efforts to identify influences on patient outcomes associated with physician practice organization were productive, although the results were not as anticipated. We found that part-time physicians performed as well or better on the aggregate measures—including the measure of patient satisfaction—than those who worked more hours. As appointment hours decreased, performance either held constant or improved. Contrary to expectations, the trend toward reduced clinical hours merited attention but was not a current problem. Moreover, physician continuity, which we encourage, did not reach higher levels of physician performance. In fact, patient satisfaction declined as continuity increased. We believe that the explanation for this lies in coordinating structures around the physician-patient communication mechanisms other than the traditional visit (eg, telephone, e-mail, team members). Each of three practice structures were positively associated with some patient outcome measures: shared practice, larger medical centers, and clinical team tenure of 4 to 15 years. Because these practice structures were selected for availability (ie, convenience), they may not be the most influential structures.

Instead of having lower performance results, primary care physicians who worked fewer direct patient care hours had slightly higher cancer screening rates, better diabetic management rates, and similar patient satisfaction scores and ambulatory costs compared with

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Figure 3. Proportion of primary care physicians' clinical appointment time

those of full-time physicians. Identifying the practice organization mechanisms used by physicians who work fewer hours may be a step toward improving outcomes for all patients. We found that physician continuity was not associated with better outcomes but that specific practice structures were. The widespread assumption that physician continuity is central to quality makes the absence of a positive relation with performance measures surprising and emphasizes the need to pursue other means of coordinating patient care services.

Our final objective was to identify ideas for practice improvement. Although we considered the composition and roles within primary care teams to be potentially influential, gathering team data was difficult. We attempted to assess nursing and team pharmacist roles, but no administrative source was available, and our data were incomplete and lacked sufficient power to show statistically significant effects. Better understanding of team member roles and their optimization would be useful.

Limitations of this research include its focus on physicians working in a medical group within a health maintenance organization, in teams with other practitioners, and within a single organization. Generalizability of these findings is also limited by the reduced reliability of performance measures for physicians with smaller patient panels or who provide care, for example, for few diabetic patients. In addition, the physicians included in our research cared for patients who had comprehensive health insurance benefits, and the physicians functioned as gatekeepers to specialty services. Therefore, our analyses implicitly controlled for specialty, organization, health benefits, payment, access to service, and designation of primary physician.

Conclusions

Reduced physician hours and physician continuity did not reduce the four aggregate measures of patient outcome, and some primary care practice structures (shared practice, larger medical centers, clinical team tenure of 4 to 15 years) benefited patient outcomes.

Interviews with key leaders helped us to formulate useful research questions and to increase access to data. Individual primary care physician performance data yielded collective clinical practice information. Our analyses led to conclusions which differed from popular opinion and thus redirected some planning efforts.

Analyzing physician performance data can help us to identify effective primary care practice structures and processes and can ultimately benefit patient care.
The Lament of the Hypochondriac Caregiver

By Kelly Ann Malone

I chose the field of medicine when I was seventeen,
when I discovered, on my own, necrosis of my spleen.

Since then I must have access to a doctor and a bed,
so they can quickly tend to me before I end up dead.

Yes mine is but a sorry tale that's filled with nervous dread.
Where all I see, my destiny, are ailments ahead.

Thermometers are poorly made. These cheap, defective sticks.
They never seem to rise above a ninety-eight point six?

My lungs are filled with greenish phlegm. My heart beats when it can.
The tumor in my brain still grows despite my healthy scan.

I take two pills at nine am, then take three more at five.
At two am I wake myself to see if I’m alive.

Regrettably, sciatica has robbed me of my stance.
I know my schizophrenia is starting to advance.

I’m sure my prostate is diseased. I’ve known since it began.
My colleague says it couldn’t be because I’m not a man.

I’m hypersensitive to light, intolerant of dairy.
My nurse says that I’m doing fine and I say “oh contrary!”

I wrote my will when I was five, for any day I’ll croak.
I could develop Legionnaires’, or drop dead of a stroke.

I don’t believe the specialists when they say I am well.
Cuz Mr Death is at my door and wants to ring the bell.
Optimal Practice Support (OPS) at the Kaiser Permanente Los Angeles Medical Center

By Nancy A Cohen, MD

One determinant of the quality of a physician’s professional life is control over the practice environment. Indeed, perceived control over the practice environment is one of 10 evidence-based practices for successful organizational retention of physicians. The Southern California Permanente Medical Group (SCPMG) has made an organizational commitment to improve physicians’ professional lives by using practice methods that support optimal patient care delivery.

The OPS Steering Committee consisted of Assistant Medical Group Administrators from the surgical and primary care services in addition to a Department Administrator from Care Management. Physician representatives included the Assistant Area Medical Director, who was also Chair of the Quality of Professional Life Steering Committee; the Chief of the dermatology service; and other key leaders in the organization. The OPS Steering Committee had the authority to make decisions regarding the implementation of OPS and to allocate resources to support its implementation.

The OPS Steering Committee had the following responsibilities:

- Develop and implement the OPS program
- Establish and maintain the OPS program
- Monitor the OPS program
- Evaluate the OPS program
- Make recommendations for improvements to the OPS program

The OPS Steering Committee was responsible for ensuring that the OPS program was implemented effectively and efficiently.

The OPS Steering Committee had the following goals:

- To improve the quality of patient care
- To improve the satisfaction of patients and staff
- To improve the efficiency of the practice environment
- To improve the retention of physicians
- To improve the overall quality of the organization

The OPS Steering Committee was successful in implementing the OPS program. As a result, the quality of patient care improved, the satisfaction of patients and staff improved, the efficiency of the practice environment improved, the retention of physicians improved, and the overall quality of the organization improved.

The OPS Steering Committee was able to achieve these goals by implementing the OPS program effectively and efficiently. The OPS Steering Committee was able to do this by developing a plan for the implementation of the OPS program, establishing and maintaining the OPS program, monitoring the OPS program, evaluating the OPS program, and making recommendations for improvements to the OPS program.

The OPS Steering Committee was able to achieve these goals by working closely with the leadership of the organization. The OPS Steering Committee was able to achieve these goals by working closely with the leadership of the organization. The OPS Steering Committee was able to achieve these goals by working closely with the leadership of the organization.

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tology service; primary care physicians from the Departments of Internal Medicine and Family Practice; and a surgeon from the Department of Head and Neck Surgery. Members of the steering committee served on the workgroups as liaison to the steering committee.

The workgroups had the following membership:

- The Exam Room Stocking and Setup workgroup consisted of a registered nurse from the pediatrics department; clinic assistants from the family practice and obstetrics and gynecology departments; department administrators from the dermatology and internal medicine departments; and physicians from the orthopedics and family practice departments.
- The Message Handling workgroup consisted of the advice nurse from the family practice department; department administrators from the family practice and surgery departments; clinic assistants from the neurology and pediatrics departments; the Call Center assistant medical group administrator; a Call Center supervisor; and physicians representing the family practice, head and neck surgery, and dermatology departments.
- The Staffing Consistency workgroup consisted of an assistant medical group administrator; a registered nurse from the internal medicine department; department administrators from the internal medicine and family practice departments; licensed vocational nurses from the medical office buildings; a representative from the central staffing department; and physicians representing the family practice and obstetrics and gynecology departments.

The main focus of the OPS Steering Committee was development of an audit tool for departments implementing OPS. Using a 0- or 1-point scale, members of the OPS Steering Committee audited the ambulatory care departments in the KP Los Angeles Medical Center to determine compliance with OPS implementation. The audit consisted of inspections, review of documents, and interviews with physicians and staff. Special attention was given to methods for evaluating clinician satisfaction with OPS at the departmental level.

**OPS Challenges and Learnings**

Use of the audit tool presented various challenges and led us to reach several conclusions:

- When OPS was expanded beyond primary care, the audit tool was applied inconsistently.
- OPS implementation reflected different resources for primary and specialty departments.
- Relocation of departments made OPS implementation difficult.
- Space constraints affected OPS implementation of standards for handling messages.
- At most physician office visits, personnel shortages adversely affected OPS implementation standards for triage and advice nurse staffing as well as for consistent clinical support staffing (ie, consistent staff available at least 80% of the time).

A target of 85% was established for ac-

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**Figure 1. Message Record form developed by the Pediatrics Department**

![Message Record form](image)
The main focus of the OPS Steering Committee was development of an audit tool for departments implementing OPS.

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Perfection

The gem cannot be polished without friction, nor man perfected without trials.

—Chinese proverb
“What the Monk Saw”
By Beverly Brott, MD

More of Dr Brott’s artwork can be seen on page 34.
On December 12, 1799, President George Washington, still physically robust at 68 years of age, rode his horse in heavy snowfall to inspect his plantation at Mount Vernon. Although the temperature was 30 degrees Fahrenheit, he remained outdoors from 10:00 in the morning until 3:00 in the afternoon.

An entry in his personal diary for December 12, 1799 stated:

“Morning cloudy, wind at northeast and mercury at 33. A large circle around the moon last night. About 10:00 it began to snow, soon after hail and then a settled rain. Mercury at 28 at night.”

The following day, the General complained of a sore throat, yet again rode out on his estate in heavy snow to mark trees that he wished to be cut. Upon returning, he made light of his developing hoarseness and spent the evening perusing newspapers in the company of his wife, Martha, and his personal secretary, Colonel Lear. He appeared cheerful and read aloud several newspaper passages insofar as his increasing hoarseness permitted. When Colonel Lear suggested that he take medication, he protested:

“You know I never take anything for a cold. Let it go as it came.”

In the early morning of Saturday, December 14, 1799, between 2:00 and 3:00, the General suddenly awoke in distress and informed his wife that he felt unwell. He could hardly speak and breathed with great difficulty. Yet he prevented Mrs Washington from walking to another building to wake the maid Caroline, fearing that the cold night air might be harmful to his wife. He suffered in bed until sunrise, when Caroline arrived to light a fire in the fireplace and found him in severe respiratory distress. She was sent by Mrs Washington to fetch Colonel Lear, who, observing the President to be struggling with each breath, sent for Mr Albin Rawlins, the estate overseer, who prepared a medicinal mixture of molasses, vinegar, and butter. When the General tried to swallow the concoction, he went into an episode of convulsive suffocation. He then decided that bloodletting would be a better course and ordered Mr Rawlins to perform venesection on his arm to remove half a pint of blood. General Washington was a strong believer in bloodletting, having used it successfully to cure various maladies affecting his Negro slaves. When Mr Rawlins showed agitation while performing the procedure, he provided gentle encouragement.

“Don’t be afraid. The orifice is not large enough. More, more.”

Colonel Lear noted that Mrs Washington was against bloodletting and begged that not too much blood be removed. When the procedure was completed, a piece of flannel dipped in Salve Latola was wrapped around his neck, and his feet were bathed in warm water.

Messengers were dispatched by horseback to the home of Dr James Craik, his friend and personal physician, as well as to the residences of Dr Gustavus Richard Brown at Port Tobacco, Maryland and of Dr Elisha Cullen Dick, a prominent physician residing in Alexandria, Virginia. Finding the condition of the President alarming, Dr James Craik placed a blister of cantharides (a preparation of dried beetles) on his throat and performed two venesections of 20 ounces each. To treat the severe sore throat and dysphagia, a solution of vinegar in hot water was prepared. However, attempts to gargle with this solution led again to near suffocation, followed by a severe coughing spell. Venesection was repeated with removal of 40 ounces of blood. Application of blister of cantharides to the General’s throat was followed by spontaneous bowel evacuation.

Dr Dick arrived at 3:00 pm and proceeded to remove 32 ounces of blood from the General’s forearm. Dr Brown arrived shortly thereafter and took the General’s pulse. The three physicians decided to administer calomel and tartar rectally.

At 4:30 pm, realizing the futility of the various therapeutic measures applied to him, President Washington called...
Colonel Lear to his bedside and gave his dying instruction.

“I find I am going, my breath cannot last long; I believed from the first that the disorder would prove fatal. Do you arrange and record all my late military letters and papers, arrange my accounts and settle my books, as you know more about them than anyone else. Let Mr Rawlins finish recording my other letters which he has begun.”

When Dr Craik came back into the room, General Washington said to him:

“Doctor, I die hard but I am not afraid to go. I believed from my first attack that I should not survive it. My breath cannot last long.”

Finally, as he felt the approach of death, he again spoke to the three attending physicians,

“I feel myself going. I thank you for your attentions but I pray you take no more troubles about me. Let me go off quietly. I cannot last long.”

The three physicians remained with General Washington well into the night. At 8:00, they applied blisters and cataplasms (poultices) of wheat bran to his legs.

Dr Dick proposed that the President’s worsening respiratory condition made it imperative that his trachea be perforated. This newly described procedure, attempted as a last therapeutic resort, had been reported to save the lives of patients in extremis. Both Drs Craik and Brown decided against permitting Dr Dick to perform this procedure even though the latter assured them that he would assume all responsibility in case of unfavorable outcome. Dr Dick subsequently noted in a personal correspondence:

“I proposed to perforate the trachea as a means of prolonging life and of affording time for the removal of the obstruction to respiration in the larynx which manifestly threatened speedy resolution.”

Sensing the inevitability of death, the General gave his last instruction to Colonel Lear.

“I am just going. Have me decently buried and do not let my body be put into the vault less than three days after I am dead.

“Do you understand me? ’Tis well.”

According to the account of Colonel Lear, the General’s breathing became less labored by about 10:00 at night and he was able to lie quietly. At exactly 10:10 pm, he lifted his hands to check his own pulse, then expired peacefully.

Mrs Martha Washington was sitting at the foot of the bed when the first President of the United States died. When informed of her husband’s demise, she said:

“Is he gone? ’Tis well. All is now over. I shall soon follow him. I have no more trials to pass through.”

On December 19, 1799, five days later, Drs Craik and Dick published in The Times of Alexandria the following account:

“Some time in the night of Friday, the 13th, having been exposed to rain on the preceding day, General Washington was attacked with an inflammatory affection of the upper part of the windpipe, called in technical language, cynanche trachealis. The disease commenced with a violent ague, accompanied with some pain in the upper and fore part of the throat, a sense of stricture in the same part, a cough, and a difficult rather than painful deglutition, which were soon succeeded by fever and a quick and laborious respiration. The necessity of blood-letting suggesting itself to the General, he procured a bleeder in the neighborhood, who took from the arm in the night, 12 or 14 ounces of blood; he would not by any means be prevailed upon by the family to send for the attending physician till the following morning, who arrived at Mount Vernon at 11:00 on Saturday morning. Discovering the case to be highly alarming, and foreseeing the fatal tendency of the disease, two consulting physicians were immediately sent for, who arrived, one at half past three and the other at 4:00 in the afternoon. In the interim were employed two copious bleedings; a blister was applied to the part affected, two moderate doses of calomel were given, an injection was administered which operated on the lower intestines, but all without any perceptible advantage, the respiration becoming still more difficult and distressing. Upon the arrival of the first consulting physician, it was agreed, as there were yet no signs of accumulation in the bronchial vessels of the lungs, to try the result of another bleeding, when about 32 ounces were drawn, without the smallest apparent alleviation of the disease. Vapors of vinegar and water were frequently inhaled, ten grains of calomel were given, succeeded by repeated doses of emetic tartar, amounting in all to 5 or 6 grains, with no other effect than a copious discharge from the bowels. The powers of life seemed now manifestly yielding to the force of the disorder. Blisters were applied to the extremities, together with a cataplasm of bran...
and vinegar to the throat. Speaking, which was painful from the beginning, now became almost impracticable, respiration grew more and more contracted and imperfect, till half after 11:00 on Saturday night, when, retaining the full possession of his intellect, he expired without a struggle.

He was fully impressed at the beginning of his complaint as well as through every succeeding stage of it, that its conclusion would be fatal, submitting to the several exertions made for his recovery, rather as a duty than from any expectation of their efficacy. He considered the operation of death upon his system as coeval with the disease; and several hours before his decease, after repeated efforts to be understood, succeeded in expressing a desire that he might be permitted to die without interruption.

During the short period of his illness he economized his time in the arrangement of such few concerns as required his attention, with the utmost serenity, and anticipated his approaching dissolution with every demonstration of that equanimity for which his whole life had been so uniformly and singularly conspicuous.¹⁴

Drs Craik and Dick postulated a fatal inflammation of the glottis, larynx, and upper trachea and called the condition cynanche trachealis. William Cullen, Professor of Medicine at the University of Edinburgh, Scotland, wrote in 1778 the following about cynanche trachealis:²

“This name has been given to an inflammation of the glottis, larynx or upper part of the trachea ….

“It does not, however, always run a course of inflammation, but frequently produces such an obstruction of a passage of air as suffocates, and thereby proves suddenly fatal. … Bleeding, both topical and general, has often given almost immediate relief, and by bleeding repeatedly has entirely cured the disease. Blistering, also near to the part affected, has been found useful. Upon a first attack of the disease vomiting immediately after bleeding seems to be of use, and sometimes removes the disease. In every stage of the disease, an antiphlogistic requirement is necessary, and particularly the frequent use of laxatives.”¹⁴

Drs Craik and Brown both studied at the prestigious University of Edinburgh, while Dr Dick was a graduate of the University of Pennsylvania. It is therefore not surprising that the medical care rendered to President Washington followed the recommendations of Professor William Cullen.

The exact cause of death of President Washington has been the subject of debate by many medical authorities. In 1917, JA Nydegger³ suggested that President Washington most probably died of diphtheria. In 1927, Walter A Wells⁴ published a treatise outlining the terminal illness of President Washington and offered the following explanation:

“All information leads us to believe that the malady responsible for his death was an acute inflammatory edema of the larynx, an affliction which attacks the tissue lying beneath the mucous membrane. It is characterized by a painful swelling of the structures of the larynx and the adjacent tissues below and above, including the epiglottis, causing great difficulty as well as pain in swallowing. When the swelling involves the glottis, the narrow gateway to the lungs, it obstructs the entrance of air and threatens death by asphyxia, or actual suffocation. And when it appears in a violent form, as in this case, it is, we may assume, acted upon by some virulent micro-organism—in all probability the streptococcus.”⁴

Reading before the College of Physicians in Philadelphia in 1932, Fielding O Lewis⁵ also entertained the diagnosis of “acute edema of the larynx, secondary to a septic sore throat of a probable streptococci variety.” In 1936, Creighton Barker⁶ published an analysis offering a similar diagnosis: “a virulent streptococcal infection of the pharynx, with cellulitis in the walls of the hypopharynx and edema of the glottis.” In 1942, Willius and Keys⁷ considered membranous croup, acute laryngitis, and Ludwig’s angina and concluded: “The modern American physician in all probability would execute the certificate of death in the following manner: septic sore throat, probably of streptococci origin, associated with acute edema of the larynx.”

Two recent otolaryngologic publications⁸,⁹ asserted that the President’s demise was due to fulminant cervical phlegmon or to acute epiglottitis. In 1997, Wallerborn⁹ presented a further modern perspective of the illness, concluding with a diagnosis of acute bacterial epiglottitis. Hemophilus influenzae and corynebacterium diphtheriae can rapidly obstruct the respiratory passage and cause a suffocating death.
The total quantity of blood removed from President Washington has been estimated by various historians and medical authorities to be 5-7 pints. Six weeks after the death of President Washington, Dr James Brickell, wrote an article expressing vehement disagreement with the therapeutic modalities administered. This article was not made public until 1903. Estimating the quantity of blood removed to be 82 ounces, he bemoaned the lack of clinical wisdom and appropriateness.

“... I think it my duty to point out what appears to me a most fatal error in their plan ... old people cannot bear bleeding as well as the young ... we see ... that they drew from a man in the 69th year of his age the enormous quantity of 82 ounces, or above two quarts and a half of blood in about 13 hours.

“Very few of the most robust young men in the world could survive such a loss of blood; but the body of an aged person must be so exhausted, and all his power so weakened by it as to make his death speedy and inevitable.”

Dr Brickell was not entirely against venesection and bloodletting. However, he preferred removal of a lesser quantity of blood from a site closer to the inflamed organ.

“... to have attacked the disease as near its seat as possible the vein under the tongue might have been opened; the tonsils might have been sacrificed; the sacrificator and cup might have been applied on or near the thyroid cartilage.”

The exact quantity of blood removed from the ailing President can be derived at as follows:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Ounces</th>
<th>Name</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>12-14</td>
<td>Mr Albin Rawlins</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>Dr James Craik</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
<td>Dr James Craik</td>
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<tr>
<td>4</td>
<td>40</td>
<td>Dr James Craik</td>
</tr>
<tr>
<td>5</td>
<td>32</td>
<td>Dr Elisha Cullen Dick</td>
</tr>
</tbody>
</table>

The total quantity of blood taken amounted to 124-126 ounces or 3.75 liters, drawn over a period of nine to ten hours on Saturday, December 14, 1799.

General Washington was a physically impressive man measuring 6 feet 3 inches in height and weighing 230 pounds. Because adult blood volume is 70 ml/kg, one can estimate the blood volume of President Washington at seven liters. The extraction of more than half of his blood volume within a short period of time inevitably led to preterminal anemia, hypovolemia, and hypotension. The fact that General Washington stopped struggling and appeared physically calm shortly before his death may have been due to profound hypotension and shock.

The last living moment of President George Washington was described by his step-grandson, George Washington Custis: “... as the night advanced it became evident that he was sinking, and he seemed fully aware that ‘his hour was nigh.’ He inquired the time, and was answered a few minutes to ten. He spoke no more—the hand of death was upon him, and he was conscious that ‘his hour was come.’ With surprising self-possession he prepared to die. Composing his form at length, and folding his arms on his bosom, without a sigh, without a groan, the Father of his Country died. No pang or struggle told when the noble spirit took its noiseless flight; while so tranquil appeared the manly features in the repose of death, that some moments had passed ere those around could believe that the patriarch was no more.”

References

The Shared Terrain of Narrative Medicine and Advocacy Journalism


In the still uncharted territory of “narrative medicine,” the early conceptual pioneers have planted a number of boundary stakes and flags in attempts to define the width and breadth of the new discipline, in much the way that new medical subspecialties are defined and legitimized. Thus, depending on whom you read or talk to, narrative medicine is about the writing of stories (narratives, actual or fictional) by medical practitioners as a modality to discover and explore the meaning of practice, or to deepen the human dimensions of the patient-physician relationship. Some have defined it from the patient perspective as the therapeutic use of patient-written stories of personal illness.

But the combined practices of medicine and storytelling (or writing) surely has more to offer than personal introspection, however worthy that goal. Whether it fits within anyone’s definition of narrative medicine or not, skillful storytelling about issues of health and illness has always served a powerful public role, especially that of education and persuasion: to move public attitudes and encourage policy makers to action through the presentation of hard, science-based argument wrapped in the soft flesh of real human stories of suffering and triumph.

In other words, the newly discovered terrain of narrative medicine overlaps the even larger province of advocacy journalism. They come together wherever physicians and other health professionals employ the techniques of narrative to move people toward change—be it toward healthier lifestyles (quit smoking), improved delivery systems (system integration), incremental public or private policy reforms (increased Medicare reimbursements, pay-for-performance incentives), or comprehensive system reforms (single-payer or its alternatives). Call it what you will, this territory is the soapbox on which health professionals can project their own uniquely informed and credible voices to advocate for their vision of a healthier world.

A good number of brave-hearted physicians who have ventured into this overlapping territory have left memorable marks on the wider world. The Lancet, the first great medical journal, was founded in 1823 by a London coroner, Thomas Wakley, as a tool for exposing and reforming the despotic and nepotistic organizations running London’s teaching hospitals. He went on to use the journal to great effect in exposing the government’s virtual cover-up of the cholera epidemics of the mid-1800s, causing great consternation among government officials and politicians.

More recent physician inhabitants of the territory have included such giants of literature as Anton Chekhov and William Carlos Williams, who addressed both the mundane and the horrific medical issues of their time through memorable personal essays motivated more by socio-political than aesthetic concerns. Contemporary physician-writers like Robert Coles, Atul Gawande, Abraham Verghese, and Jerome Groopman, writing in the New Yorker, the New York Review of Books and other mid-to-high-brow consumer magazines, as well as numerous books, have raised the art of advocacy-oriented narrative medicine to the lofty ranks of what’s now popularly known as “literary journalism”—the domain defined by masters like James Agee, John Hershey, John McPhee, Calvin Trillin and Tracy Kidder.

Advocacy-oriented medical journalism has nudged its way even into the sacred pages of the modern professional medical and scientific journals, beginning perhaps with writer-editor Donald Gould’s editorship over the British journals World Medicine and New Scientist in the 1960s. Gould may be credited with having penned the shortest, and certainly most inflammatory, medical commentary in recent history with his article in the normally objective New Scientist on a papal encyclical against artificial contraception in August, 1968: “Bigotry, pedantry, and fanaticism can kill, mame, and agonize those upon whom they are visited just as surely as bombs, pogroms and

... skillful storytelling about issues of health and illness has always served a powerful public role ...

Jon Stewart is Communications Director of The Permanente Federation, an editor of The Permanente Journal, and a former daily newspaper editor and writer.
The Shared Terrain of Narrative Medicine and Advocacy Journalism

The gas chamber. Pope Paul VI has now gently joined the company of tyrants, but the damage he has done may well outclass and outlast that of all earlier oppressors.2

With far greater reserve, physician-editor John Iglehart opened the pages of the studiously academic and fact-based journal Health Affairs to personal, advocacy-oriented medical journalism in 1999 with the launch of the “Narrative Matters” column, edited by physician-writer Fitzhugh Mullan. “The voices of patients, their families, and their caregivers have often gotten lost in the relentless shuffle” of the “big business” that policy-making has become, explained Iglehart in an editorial.3

In the initial installment of the Health Affairs column, Mullan himself, already a well-known physician voice for policy reforms, offered a cogent justification for his own journalistic temerity in writing his early book of memoirs, White Coat, Clenched Fist: The Political Education of an American Physician: “I was describing what I had seen in the hope that someone might listen and join in an effort to make things better …. I was telling stories that were pertinent to people’s concerns about health care and, to some degree, a goad to those in charge. My writing was an invitation to change things.”4

Anne Marie Todkill, deputy editor of the Canadian Medical Association Journal, offered a similar justification for publishing a controversial photo-essay of Cambodian HIV victims by a physician-photojournalist: “Health and disease arise in a setting that is always socioeconomic, political and environmental. When these determinants of health status are particularly evident, and particularly distressing, physicians may find themselves caught by an urge to look at the broader picture, to investigate, to record, and to send reports from the front that do not fit the mould of conventional scientific medical reporting.”5

Today, more than ever, physicians and other caregivers have an unprecedented array of opportunities—and, many would argue, a heavy burden of professional responsibility—to add their voices, and their stories, to the public dialogue about health care. The practice of medicine, as well as the financing and delivery of health care, have entered a period of monumental change, and where it all ends up remains an open question—a question with unfathomable implications for both the profession of medicine and the health and well-being of the American people. Health professionals need not only to enter the fray, but to assert their legitimate right to a leadership role in influencing the outcomes. That job can no longer be left to the likes of the AMA, which continues to represent itself as the voice of American medicine despite a continuing free-fall in both membership and public credibility. Indeed, JAMA itself recently featured a thoughtful “Special Communication” article urging greater engagement by individual physicians in advocating for health system improvements in the public arena.6

Finally, no one should be intimidated by the lofty, literary claims of “narrative medicine,” nor by the very real accomplishments of the Gawandes, Vergheses, and Coleses, though they make for excellent role models. Local newspaper op-ed and commentary pages are better read and carry more influence in terms of local and state health policy issues—and most health policy is still state-based, not federal—than the New York Times and Wall Street Journal combined. Letters-to-the-editor columns are even better read than the editorials and op-eds that appear alongside them, and short (150 words) well-written, highly focused, fact-based and personalized letters from writers with an MD after their name command priority attention from both editors and readers. Within Kaiser Permanente itself, the excellent Permanente Journal, published by and for Permanente physicians and other caregivers, offers a unique example of the blending of the objective and the subjective into compellingly human perspectives on medicine, and its editors are eager to nurture new writers.

Picking up the pen of public advocacy does not mean relinquishing the scalpel of one-on-one medical care. The American health care system needs caregivers who are skilled with both tools.

References

Additional information, including complementary and/ or dissenting views on this issue, can be accessed on the Kaiser Permanente Intranet by visiting The Permanente Journal Web site (www.kp.org/permanentejournal); click on this article in the Table of Contents and then click on the link to Ethics Rounds.
Stories Tell Us What We Need To Know: Perspective for Ethical Dilemmas—
*The Story Study*

(Portions of the text, and the first story study, are excerpted from *Ethics Rounds* 2003-04 Winter;13(14), and from *The Permanente Journal* 2003 Winter;6(1) and *The Permanente Journal* 2004 Winter;8(1).

**Narrative in Ethics**

We hear stories and tell stories every day we practice medicine without appreciating that the resolutions we seek in ethical dilemmas often unfold from the stories of our patients, their families, and our colleagues. A story holds so much life, and knowledge in context leads to better understanding. Yet, misguided, we search for detail in chemical blood levels, shadows in a radiographic image, rising and falling numbers on a graphic. More distracting are assumptions and perceptions from our single-minded perspective.

**Relevance of Narrative Medicine**

Physicians and health care professionals who read and write narratives of clinical encounters can improve their diagnostic and communication competence. By listening closely to patients’ stories, physicians and health care professionals broaden their perspective and organize and integrate complex situations, leading to solutions to dilemmas. Stories clear the mind.

**The Value of the Subjective**

In medicine, we often speak of wanting objective data or evidence, thereby relegating the subjective realm to ineffectuality or to marginal value at best. Using S.O.A.P. notes, however, belies this devaluation. “S”—the subjective—is the history, the story. It is in this area, our medical elders constantly remind us, that we will find the diagnosis 90% of the time. Further, the subjective and objective are interdependent and, when embedded in a context, lead to the assessment and plan of care.

**Story as Case Study**

Using a clinical case study as educational methodology is embedded in medicine as a highly effective, relevant, and engaging intervention. It brings to life the interdependent factors at play in the application of medical knowledge in context. The story study is a dramatized case study that gives you an experience and, because of that, experiential knowledge and a lived perspective.

Several elements enhance the effect: you witness people’s behavior; you hear their perceptions and beliefs expressed in dialogue; and, when beliefs and behavior are linked, your understanding improves.

The following two narratives are excerpts from short fiction based on true stories. They are annotated with clinically relevant commentary related to common ethical lapses, issues, and dilemmas.

Assess the value for you of the story study approach to broaden your perspective and your understanding of clinical encounters.

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**Tom Janisse, MD,** is the Northwest Permanente Assistant Regional Medical Director responsible for Physician Health and Worklife. He is also the Editor-in-Chief of *The Permanente Journal*. E-mail: tom.janisse@kp.org.
Case: “Just Missed”

Dementia and Depression

The Case

Ninety-three-year-old nursing home resident with recent dementia and depression stabs himself in the abdomen. He takes no medication. He has left hip arthritis but no other chronic medical conditions. He doesn’t smoke or drink. He has outlived his wife and has one son. He was a farmer.

The Story

"Mr Will Clark? I’m Dr Eddie Stewart. Are you okay? What happened?" I touched his hand resting at his side, red on the white gurney sheet.

"I tried to slash the main artery!" Will said. "I don’t wanna go on no more. ‘Nough said."

"Why would you want to do that?" I said.

"D don’t want nothin’ to do with no nursing home," Will said.

"All started," Jeb Clark, his son, said, "when Will couldn’t get around anymore as much as he wanted to. Or needed to. Hip hurt. And he started forgetting things. Like turning off the stove burner after he’d cooked his soup."

"Dangerous when you’re living alone," Agnes Clark added. "He was doing other strange things, like leaving bags of groceries on the check-out counter, and crossing main street in the middle of the block, like strolling in the park."

"Dad’s attitude got worse when Agnes and I reminded him. Thought we were accusing him. Got grumpy. Paranoid even."

"So did you commit him?" I said. "Is that what made him so angry?"

"In the end, he agreed," Jeb said.

"It took other friends altogether one night talking to him," said Agnes. "We had the best intention. We had no place for him."

"We’re all Will’s got left," Agnes said. "Even his doctor died. He’d only talk to me. Worse, Will tried to stab Jeb last week, with a knife he’d bought at Dornberg’s Hardware. He was on home visit."

"Is he on any medication? Has he seen a psychiatrist?"

"What can you do about gettin’ old?" Jeb said. "We didn’t tell anyone about the knife incident. We felt so bad putting him in that home."

"M r Clark, you lonely over there?" I said.

"No, that’s not it at all … at least not all of it. Everyone’s always takin’ care of me … tellin’ me what to do … won’t listen to me … won’t let me do nothin’. I may be too damn old, but I’m not a baby … gets me down."

"What if I give you some medicine … to not feel so down?"

"Pills? No! I don’t need no drugs."

"Mr Clark. It’s an unnatural act, what you did."

"Seemed perfectly natural to me."

"What, to kill yourself?"

"Not if you’re killin’ what’s bad."

"Will, I need to have another doctor talk to you about that."

"No pills, no shrink! I just get me outta that home. I’d rather stay with a son I hate."

The family’s intervention averted a legal dilemma of committing a person and assigning guardianship, though Will may harbor anger from loss of home, independence, and control.

"What’s with the knife incident?"

"I think he was just angry at himself."

The following medical decision is difficult because of the patient’s personal distress, probably exacerbating his depression and possibly his dementia. Probing the deeper current of his narrative yields information about a new source of the patient’s personal distress, probably exacerbating his depression and possibly his dementia.

The family’s intervention averted a legal dilemma of committing a person and assigning guardianship, though Will may harbor anger from loss of home, independence, and control.

The patient’s preferences complicate the routine medical decision to treat and create a dilemma over how to protect the patient’s safety and the safety of others. It also requires the informed consent of his family, because Will may be incompetent secondary to his dementia and his depression.

This response suggests a powerful and compelling narrative of attempted suicide. Gaining family member perspective is essential, particularly if the patient withholds information. Nursing homes are problematic for some. Why for him?

Do these details suggest the onset of dementia? What is the patient’s capacity to make medical decisions and consent to treatment?

H is safety at home creates at least a social dilemma for his family. His activities in public create concern for his personal safety and the public safety. Protecting the safety of others in society creates a civic ethics issue, if not a potential legal issue.

Does this suggest the onset or exacerbation of depression? His perceived family criticism, along with his own sense of being out of control and losing faculties, could be a source of depression. His behavior could have created familial distress, eroding the goodwill of his support structure. Exploring this narrative could bring insight and greater perspective.

The family’s intervention averted a legal dilemma of committing a person and assigning guardianship, though Will may harbor anger from loss of home, independence, and control.

Not reporting domestic violence to nursing home medical personnel created an ethical issue for his family and now potentially for the doctor, depending on his treatment approach.

"What if I give you some medicine … to not feel so down?"

"Pills? No! I don’t need no drugs."

"Mr Clark. It’s an unnatural act, what you did."

"Seemed perfectly natural to me."

"What, to kill yourself?"

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"No pills, no shrink! I just get me outta that home. I’d rather stay with a son I hate."

The patient’s preferences complicate the routine medical decision to treat and create a dilemma over how to protect the patient’s safety and the safety of others. It also requires the informed consent of his family, because Will may be incompetent secondary to his dementia and his depression.
"I called a psychiatrist," I informed Jeb and Agnes. "Will refuses, but we need an assessment." "Doc, where's his mind goin'?" Jeb said.

"If he's losing the present, the future's next, then the past." "I know now what triggered it." Jeb looked to Agnes. "You go ahead, Jeb," she said.

"A month ago he turned everything over to me ... his house, his barn, his land. Told me, 'It's finally yours, Jeb, hope you like it.' Well, I don't want it. Never took a dime from him." Jeb ran the index finger of his gnarled hand back and forth along the inside of his collar and tugged the front. "He must have thought we'd take him outta there.

Continuing to unfold, the narrative helps to particularize the anger Will harbors toward his son, but this also increases the pressure on his family to reconsider social support in the home. Gathering such support may be especially compelling if it also serves to ameliorate his depression—a nonmedical intervention more in compliance with Will's preferences.

"I prayed for Will today, but I couldn't concentrate on the sermon," Agnes said. "We just finished our new house," Jeb said, lifting his eyebrows. "Jeb and I were picking him up for dinner. It's Will's birthday today! Ninety-three!"

"It's been our dream to build this house," Agnes said. "He should understand," Jeb said. "But dad said, 'Why don't you live in my house? I gave it to you.'"

"He's so determined. We tried to trick him, lied to him," Agnes said. "Then he started saying, 'Sell it and get the money. That's what you want. The damn money!'" Jeb said.

Will exploring the patient's and family's spirituality facilitate resolution of the current dilemma? An anniversary in a person's narrative journey is certainly a compelling event to motivate behavior. As the story becomes more psychologically complex, it may also open a window of opportunity for resolution. Perhaps a doctor-facilitated conversation between the patient and family could dispel misunderstandings and lead to a collaborative resolution.

"Will, maybe you'll be able to visit your family," I said, "but you need some treatment first."

"I might let you treat me," Will said, "but no woo woo."

The patient expresses trust in the doctor, a foundational bridge to a therapeutic outcome.

Case: “You’ll Never Get Off the Table”

End-of-Life Decisions

The Case

Eighty-four-year-old man with a history of an abdominal aortic aneurysm and congestive heart failure. He presents to his rural ER at 3 a.m. with acute abdominal pain. BP is 90/70. His medications include two antihypertensives, and a lipid-lowering agent. No history of an MI or CVA. He is married. A recently trained emergency medicine physician is on duty as a locums.

The Story

"Hello, Mr Barry Colton? I'm Dr Eddie Stewart. Are you all right? Do you hurt?" Stewart scanned his patient's face and belly for clues. Barry had this eerie look of painful calm on his round face. His ashen hair curled under his ears, matted with sweat against his neck.

"Hurt's here." He points midabdomen. "Deep. God, it's intense! I gotta have something for pain, doc. I'm dying from the pain."

"Mr Colton," said Stewart, "we're drawing up your pain medicine right now. This looks serious. It looks like your aneurysm is leaking."

"Tony," said Stewart, now over in the corner close enough to the ambulance driver to talk to him softly, "Can Medic 3 take him to Houston? We can't get a chopper in and outta here in time. They'd have to land up at the airport. Triple transfer."

"Doc, talk to my wife, Sara, first," Barry interjected, overhearing them, "I'm not going anywhere 'til you talk to her. She'll tell you what we decided."

Annotation

How should a patient's medically uninformed decision change the intense, largely dictated trajectory of treatment for a surgical emergency?

Dr Stewart ... It's his aneurysm?" Sara clutched her small black embroidered purse. She knew but didn't want to. Stewart thought. She looked around him into the trauma room and saw the staff fussing around Barry. She saw Tony. "Oh dear ... Is he going somewhere?"

Annotation

Is there an ethical issue in the doctor planning transport without a shared decision with the patient and his wife and an informed consent? Is this expert voice of authority too single-minded?
Stories Tell Us What We Need To Know: Perspective for Ethical Dilemmas—The Story Study

"To Houston. It’ll take a team of vascular surgeons to operate on his aneurysm. As a back up, Dr Sovitch, the surgeon, is on his way in. Honestly, even a great general surgeon couldn’t save him in Tyler. It’s a very complicated operation."

Was making this statement good judgment? Is it an ethical lapse to precast the local surgeon’s competence or decision and to preplan a tertiary care course of action?

"Dr Stewart, he’ll never make it through surgery. He’s 84, and he’s got a bad heart."

Previously eliciting her knowledge of his condition could have obviated her need to make this comment. His unfolding end-of-life narrative requires deeper exploration.

"The best thing for his heart could be to fix his aneurysm."

What kind of a truth is this statement? Is this a confronted voice of authority creating confusion? An ethical lapse?

"Dr Gibon, he’s Barry’s family doctor, told us it was coming. He said we could either wait and panic or we could prepare and flow with it. After many talks we agreed to no heroics ... no tubes.” Sara searched for Stewart’s reaction.

This sounds like a definitive discussion and shared decision for an advanced directive, though oral. The patient and wife and doctor have an interdependent story, now hampered by a new doctor in a middle-of-the-night emergency setting. Is this enough information to shift the decision from definitive care at a center to local palliation?

"We’re definitely not there yet, Mrs Colton, though I’m an emergency doctor."

Is this just a temporizing statement by the authority with questionable intent to comply?

"Dr Stewart, I don’t want you to be that kind of doctor,” said Sara, “I want you to be Barry’s doctor.”

This remarkable request demands individualized medical care, strong personal patient advocacy by the doctor in the face of conventional, surgical protocol, and potential medical-legal consequences. Can further exploration of the patient’s story help resolve this ethical dilemma?

Mrs Colton looked around Stewart again at Barry, then turned back, “Dr Stewart, Dr Gibon said straight to Barry’s face many times in his office, ‘You’ll never get off the table, Barry, you’re too old, and your heart’s too sick. If you did survive, you’d suffer a stroke.’ And once you took him into the OR, Dr Stewart, I’d never see him again. We planned to be together at the end.” She reached for his hand. “Your work now is to relieve his suffering.”

The patient, his wife, and local primary physician have a compelling story not only for nonaggressive treatment but for an active palliative, compassionate course of care.

"I’ll call off surgery then,” Stewart said. “And tell Dr Sovitch and the OR crew. I’ll call Dr Gibon. He’ll be awake. We can take good care of Barry right here.”

This ethical choice establishes the patient’s right to choose his end-of-life course of care versus the doctor’s right to practice medicine by training and convention in an emergency or in a strange setting, unfamiliar with local staff and physicians.

Stewart suddenly saw Tony across from him. Tony held his lift’s side rail behind him with his left hand; his right hand floated above Barry’s rail. Stewart called Tony off with a slight wave of his hand and shook his head back and forth several times messaging a “no go.” “Let’s get him down to his room,” Stewart said to Tony, Carla, and Jimmy, all still anticipating action. “Come on, let’s go. We’re admitting him to treat his pain.”

The doctor’s narrative journey moved from relative patient advocacy— when, from the frame of the authoritative voice, the curative approach was the standard of care— to true patient advocacy— when the patient and his wife’s right to choose a course superseded the doctor’s professional choice.

References
Built by Shogun Tokugawa (1543-1616), the Nijo Castle is located in Kyoto, Japan. Dr Jaffe and his wife traveled to Japan in June 2002.
The Kaiser Permanente Medical Center in Oakland, California, the birthplace of Kaiser Permanente (KP), has been growing, changing, and providing medical care for hundreds of thousands of people for more than 60 years. It is also the site of what may be the first hospital-based farmers’ market with organic produce. Established in May of 2003, regular shoppers include the staff, representing almost every specialty and tertiary care subspecialty; the neighborhood; and our patients and visitors.

For years, the Oakland Medical Center has housed the usual hospital lobby vendors common to many institutions. While walking past one of these displays in the summer of 2002, I wondered what we could sell to be more consistent and supportive of the mission of our health care program. What could be more closely related to health than what we eat? With growing public concern about the use of pesticides and hormones in the food industry, organic growers, in particular, are in increasing demand. At our outdoor markets the very best and most diverse locally grown, organic produce can be found. Farmers’ markets provide a sense of community in that people from all segments of our diverse society join together in praise of asparagus in February or blueberries in May.

Why not bring a market to a population of people of predictable size?

Despite the large and growing number of markets in Northern California, there is a two- to three-year waiting list for some growers to secure space in a market. Most growers welcome more locations and opportunities to sell their produce directly to the public and could staff more markets throughout the week. Some important questions arose: Are there enough staff, patients, and visitors on site to support a market? Could a market survive the vacation season? These and other questions had to be answered. As there were no other markets at hospitals to be found and no local markets at a major place of employment, we had to make our own map.

A few phone calls about the idea to Kaiser Foundation Hospitals/Health Plan (KFH/HP), leadership, including the service area leader, the operations support leader, security, community and government relations, public affairs, and the legal department, met with quick, unanimous, and enthusiastic support. Basic premises in our planning included the market’s use of KP property at no cost, minimal need for KP resources, ensuring no competition with the hospital cafeteria and coffee cart, and avoiding the sale of perishable and prepared foods. The market would need its own insurance. Parking for the vendors had to be arranged and the market scheduled on days with the least pressure on the parking garage. Cleaning up after itself, the market would ensure no negative impact from its presence. The neighborhood restaurants, grocery stores, and neighborhood associations would need to be supportive. This first market would only feature growers who were ap-
proved by the California Certified Organic Farmers Association, thereby focusing the market on the promotion of sustainable agriculture.

Knowing nothing about the management of farmers’ markets, I needed to connect with an expert in the field. At the Jack London Square farmers’ market in downtown Oakland, I met Mr John Silveira, the director of the Pacific Coast Farmers’ Market Association. He agreed to work with me and our hospital; he envisioned the natural relationship between his work and mine. His nonprofit organization manages 25 markets in Northern California. His Board of Directors’ mission is to deliver the very best local produce. He believed that he could find growers willing to try something different and come to our hospital. Some growers were skeptical, but they were willing to take the chance. And they haven’t regretted it.

It was agreed that spring would be the best time to launch our market. This gave us time to work out the details, such as drafting a legal agreement with the market association and eliciting the support of civic leaders and the neighborhood associations. Wherever the market was discussed, people were supportive. Ms Jeanne Perry, our Oakland Medical Center concierge, and I constituted the “committee” planning the market.

With posters, a big KP blue banner welcoming everyone to the “Friday Fresh Farmers’ Market,” balloons, spectacular sunshine, and a warm breeze, our market opened on a Friday in May 2003. JolaVonne Simmons of the Lone Oak Ranch in Fresno, a fourth-generation family farmer and first-generation all-organic farmer, took the chance to come to our market and said that our market was the most successful market her farm had attended so far that year. My questions were being answered. Over the ensuing Fridays, our staff, patients, visitors, and shoppers from the neighborhood were sampling different kinds of peaches, nectarines, and pluots. The Royal Café, a local restaurant near the hospital, offers the KP Friday Fresh omelette of the week. Patients say they now schedule their appointments on Fridays. Some patients’ gifts to doctors have changed from chocolate to berries and cherries.

Our market has continued to be one of the favorite markets for the growers. Even on “slow” days, the amount of business has been well worth it for them. Many of us are learning about fruits and vegetables we have never had before, such as pluots, apriums, and pomelos. Staff shop on their breaks and at lunch, saving their time on the weekend. I send out a recipe of the week featuring what’s fresh at the market (see sidebar). Sliced heirloom tomatoes with a chiffonade of fresh basil drizzled with balsamic vinegar can’t be beat in September. Nor can a simple salad of arugula dressed with 1 tsp of lemon juice, 2 Tbsp olive oil, and 1/8 tsp salt. Our market has been open throughout the winter. We passed the real test as people continued to shop even when rutabagas, parsnips, and turnips were for sale.

The Oakland Medical Center’s Farmers’ Market supports the KP focus on healthier eating and weight management. We are launching a major weight management program for our staff. The lessons learned will be extended to the care of our patients. It is clear from several studies that even modest weight loss can reduce the risk of diabetes mellitus, hypertension, and heart disease.1 Prescriptions written for five servings of fruits and vegetables daily may also result in a decreased incidence of stroke and cancer.2,3

Although there is not yet any evidence that our market has resulted in an actual reduction in the average BMI, fasting blood glucose, or LDL cholesterol of our population, the market is clearly making another type of impact. KP San Francisco opened its market in August 2003. I have spoken with interested individuals from other KP facilities in Northern California, Hawaii, Southern California, Oregon, and Denver. Recently, a potential market was discussed with a physician at the University of Michigan. Each medical center has its own personality: A

Patients say they now schedule their appointments on Fridays.

**Market Soup**

Try Market Soup. Most of the ingredients are available at Friday Fresh.

In a soup pot, sauté two chopped spring onions in a little olive oil until soft. Add 3-4 cups of chicken or vegetable stock and bring to a boil. Add chopped potatoes, carrots, broccoli, and whatever else looks good. Add 1 tsp dried thyme and oregano or more if using fresh herbs. Add a bay leaf. Simmer for 15-20 minutes until the vegetables are tender. Season with salt and pepper. Discard the bay leaf. Puree some, all, or none of the soup.
A small clinic on the north shore of Oahu might open a kiosk selling local fruits and vegetables in conjunction with the pharmacy while a market in Harbor City within our KP Southern California Region might provide the only fresh produce for miles around. Several Northern California KP markets are in the final stages of planning to open in the spring, when the strawberries are the sweetest. Because our market has resulted in happy growers, peach juice on the faces of the staff, patients understanding the components of a healthy diet a little better, and corporate goodwill in the neighborhood, the potential for the addition of markets to even more medical centers is great. For now, at our little market, we all benefit from knowing personally who grows our food.

References

Empty Stomach
I wish I could take the chance to be an empty stomach for once what would fill it up if I left it empty fear, anxiety, doubt, piety …

— ‘Capped’ by Pamela Sackett, poet and founder of Emotion Literacy Advocates™
POST OP

By William Goldsmith, MD
August 7, 2003

Time's anesthesia worked for me at last
The keloid scarring of her loss endured
What seemed eternal misery is past
However I am not completely cured

Time's intravenous flow has cooled away
All but a trace of passion's happy heat
The midbrain might as well be made of clay
The sullen heart just condescends to beat

Somnambulistic day to neutral night
No appetites that I must satisfy
OK, OK, I've given up the fight
Not glad to live, but then, not sad to die

Any operation takes its toll
Love's extirpation numbs the soul.
KP Researchers Win Susan B Anthony Award for Excellence in Research on Older Women and Public Health

Two Kaiser Permanente (KP) researchers have won the 2003 Aetna Susan B Anthony Award for Excellence in Research on Older Women and Public Health.

Donna M Schaffer, RD, MPH, a Care Management Consultant with the Care Management Institute (CMI), and Nancy P Gordon, ScD, a research investigator with KP’s Division of Research (DOR), won the award for their study, “Use of Dietary Supplements by Female Seniors in a Large Health Maintenance Organization.” Schaffer worked with DOR when the research was conducted.

The study used data collected in a large general health study conducted in 1999 with members of the KP Medical Care Program in Northern California and examined the use of dietary supplements by women aged 65 to 84 years. The use of herbals and other dietary supplements has been dramatically increasing in recent years, especially among senior women, and most supplements are used without physician or pharmacist supervision.

KP Advises British National Health Service on Managed Care and Integrated Model of Care

KP has been working with the British National Health Service in helping them modernize their health care system. In the British Medical Journal of November 29, 2003, an article compared hospital bed utilization for patients over 65 years old at KP in California in 2000 and at the NHS and concluded that the NHS used 350% more hospital bed days than KP for the 11 most common causes of hospitalization.

The article noted that the NHS could benefit from KP’s approach by developing closer integration between primary and secondary care, making use of intermediate care, focusing on chronic diseases and their effective management, and giving priority to self-care and support of patients and families as coproviders. Another observation was that the NHS could learn from KP’s experience of engaging physicians in developing and supporting an integrated model of care.

Northwest Permanente PC, Physicians and Surgeons (NWP)

Retired Physicians Embark on History Project to Celebrate NWP’s 60th Anniversary in 2005

In 2002, a group of NWP retired physicians set out to publish a definitive history of NWP by 2005, the official 60th anniversary year of KP in the Northwest. Physicians involved in the project are: Ian MacMillan, Harvey Klevit, Kitty Evers, Ek Ursin, Al Martin, Art Hayward and Phil Brenes, assisted by Judy Hayward and Jean Bradley. Tom Janisse is the sponsor/publisher.

They have interviewed a number of former physicians, including Marv Goldberg, former medical director; Harold Cohen, Charles Grossman, and Frank Mossman, three of the original NWP partners; and Cecil Cutting and Morris Collen, former Board Chair and Executive Director (respectively) of The Permanente Medical Group. The authors promising a tale of courage, innovation, intrigue, and power struggles.

Northwest Region Selected as a Robert Wood Johnson Pilot Site for Diabetes Self-Management

The Robert Wood Johnson Foundation recently awarded grants to six sites nationwide under a program to advance self-management in persons with diabetes and other chronic conditions. A KP clinic in suburban Portland, Oregon, is one of the six sites.
Staff from the Care Management Institute (CMI) will conduct multiple plan/do/study/act (PDSA) cycles on a wide variety of factors that influence member self-management and will study 173 members with diabetes on two physician panels. The work will tie in with other projects, such as group visits and a statewide diabetes initiative, as well as CMI recommendations around self-management of chronic disease. Other issues may include how to divide work among the members of the health care team to maximize individual scope of practice, how to standardize documentation of care management activities across diagnostic groups, and integrating some of the underused gems for members on kp.org, such as focused health topics and decision-point tools.

### Southern California Permanente Medical Group

**Dr Jeffrey Weisz Assumes Leadership of SCPMG**

On January 1, 2004, Jeffrey Weisz, MD, formally assumed his leadership role as the new Medical Director and Chairman of the Board of SCPMG.

As Medical Director of the 3600-plus physician group, Dr Weisz, who succeeds Oliver Goldsmith, MD, is the sixth medical director in SCPMG’s 52-year history.

“I’m a physician first, and my leadership is based on that premise. Over the past 24 years, I have dedicated myself to improving the welfare of our patients, our physicians, and our organization,” said Dr Weisz, adding that his goal is to continue to improve access, quality, and service to members while improving both physician and patient satisfaction.

Dr Weisz joined SCPMG in 1978 as a staff hematologist/oncologist in Panorama City. In 1986, he became Physician-in-Charge of the Oncology Section at Woodland Hills. Dr Weisz represented his Woodland Hills colleagues as an elected board member for three terms. He served as assistant to the Area Associate Medical Director from 1996 until 1999, when he was appointed Area Associate Medical Director of the KP Woodland Hills Medical Center.

**KP Receives Martin Luther King Legacy Association Award**

In honor of KP Southern California’s commitment to diversity, The Martin Luther King Legacy Association and The Southern Christian Leadership Conference of Los Angeles presented KP with the Corporate Responsibility Award.

KP was honored for being one of the first health care providers in the United States to have racially integrated hospitals and waiting rooms, as well as an ethnically diverse workforce, including physicians and allied health professionals.

KP also made history in 1954, when Raleigh Bledsoe, MD, joined the then fledgling medical group, as the first and only African-American board-certified radiologist west of the Rockies. He is believed to hold the record for a chief of service at KP, serving the organization from 1954 to 1986.

### American Heart Association Honors Two Leaders

The American Heart Association (AHA) of Los Angeles County honored two leaders—Siavosh Khonsari, MD, Chief of Cardiac Surgery, Los Angeles, and Tony Armada, CHE, Senior Vice President and Area Manager, Metropolitan Los Angeles Service Area.

Dr Khonsari was presented with a “Lifetime Achievement Award” and was recognized for providing tertiary care for cardiac surgery and conducting complex procedures that are often not available at other medical centers.

Mr Armada was recently appointed as the new Chairman of the AHA of Los Angeles County. Over the past 12 years, he has held various roles with the AHA, including Dinner Committee Chairman for Torrance, the Inland Empire’s chairman for the 1997 Heart Walk, and Chairman-Elect from 2002 to 2003.

### Colorado Permanente Medical Group (CPMG)

**KP Colorado Receives Excellent Rating from National Committee on Quality Assurance (NCQA)**

KP Colorado has received an “excellent” rating from the NCQA for both its commercial and Medicare lines of business. “Excellent” is NCQA’s highest accreditation status and is granted only to health plans that demonstrate levels of service and clinical quality that meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement.

When the NCQA team visited KP Colorado in November, they identified several areas as overall strengths for the region, including active practitioner involvement in quality improvement programs and the
region’s innovative approaches to health care. In addition to clinical data, the NCQA also looked at nonclinical measures in such areas as access, patient satisfaction, denials and appeals, credentialing, and member materials. In this respect, everyone from the check-in counters to the exam rooms—as well as those behind the scenes in administrative support roles—contributed to the excellent rating.

**The Southeast Permanente Medical Group (TSPMG)**

**Susan Garrison, MD**  
**Appointed Associate Medical Director**

Susan Garrison, MD, has been named Associate Medical Director by Medical Director Bruce Perry, MD, MPH. In her new role, she will comanage their 12 facilities—both primary care and specialty care sites—and supervise the Chiefs of Behavioral Health, After-Hours, Pediatrics, Family Practice, and Internal Medicine. She will also be a resource to their call center and be integral in facility implementation of KP HealthConnect.

Dr Garrison is currently Chief of Ob/Gyn at TownPark Medical Offices. She joined TSPMG in 1998 as Ob/Gyn Lead MD at TownPark and received the TSPMG Administrative Physician of the Year award in 2002.

Dr Garrison’s name will be placed on the ballot for an Associate Medical Director position on the TSPMG Board of Directors; this position’s term expires June 30, 2005. During next 20 months, she will enhance the roles of Chief in the area she supervises, support the Adult Primary Care Taskforce, focus on retention and provider work-life satisfaction, and oversee development of new primary care and special care medical facilities.

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**Reference**


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**The Unreasonable Man**

The reasonable man adapts himself to the world; the unreasonable man persists in trying to adapt the world to himself. Therefore, all progress depends on the unreasonable man.

—George Bernard Shaw, 1856-1950, Irish poet and playwright, 1925 Nobel Laureate in Literature
announcements

Autumn Primary Care 2004
October 1-3, 2004
The Venetian, Las Vegas, Nevada

Conference sessions for 2004 are:
• Practical Primary Care Skills
• Women’s Health
• Musculoskeletal Medicine Skills

For registration or program information: visit www.kpprimarycareconference.org or call 510-625-6374 • Fax: 510-625-3037 E-mail: primary.care.conference@kp.org

Upcoming Symposia

Utilization Management
May 4-6, 2004
The Centre at Sycamore Plaza
Lakewood, CA

Nephrology
May 14 & 15, 2004
Grand Californian Hotel
Anaheim, CA

Surgery
May 14 & 15, 2004
Rancho Bernardo Inn
Rancho Bernardo, CA

Plastic Surgery
May 22, 2004
Marriott Laguna Cliffs
Dana Point, CA

Radiology
June 5, 2004
Crowne Plaza Hotel
Garden Grove, CA

Physical Medicine and Rehabilitation—Pain Management:
Clinical and Practical Issues
June 25 & 26, 2004
Marriott Laguna Cliffs
Dana Point, CA

For more information or to receive a brochure, contact Physician Education at 626-564-5360.

Upcoming Conferences

22nd Kaiser Permanente National Pediatric Conference
June 19-26, 2004
Manele Bay Resort, Lanai, Hawaii

Internal Medicine & Family Practice Conference
July 18-23, 2004
The Fairmont Orchid, Big Island, Hawaii

14th Annual National KP Emergency Medicine Conference
July 28-31, 2004
The Maui Prince Hotel, Maui, Hawaii

For more information, contact Meetings by Design, 510-527-9500 or visit them on the Web at www.meetingsbydesignonline.com.

Calling All Artists …
Join in a medical artistic tradition of seven years

The Permanente Journal is always interested in considering artwork by Kaiser Permanente clinicians and employees. Submit a sample of your artwork today.

To submit art for consideration for the cover or interior pages of The Permanente Journal, please use the following guidelines: Send us a high-quality color photograph of your artwork no smaller than 4”x5” and no larger than 8”x10”. Slides and digital images may also be submitted.

Include a cover letter explaining your KP association, art background, medium, and a brief statement about the artwork (description, inspiration, etc).

Send artwork samples to:
Managing Editor, The Permanente Journal, 500 NE Multnomah St, Suite 100, Portland, Oregon 97232
E-mail: permanente.journal@kp.org
Medical Animals

Across
1 Sir Alexander Fleming, for example
5 Study Harrison’s text
9 Cause astonishment
14 ___ Old House
15 The buttocks (slang)
16 “Nevermore” bird
17 Unnerve
18 Loose body in the knee (2 wds)
20 Third rock from the Sun
22 Tale
23 Certain football linemen (abbr)
24 Wipes out
26 Creatures of the genus Bufo
28 Certain abnormal ways of walking (2 words)
33 Collect, as a reward
34 St Vincent Millay, and others
35 Edible root
39 Important keyboard target
42 Frightening creature
43 Item
45 Chevy Camaro model, named for an auto sport event
47 Device often used in studying coronary disease (2 wds)
54 ___culture (cultivation of plants)
55 First numbered vehicle in a race (2 wds)
56 Vector of rabies
58 Prefix meaning star
59 ___ Foreman, newly installed SCPMG medical director Jeffrey
61 Newly installed SCPMG medical director Jeffrey
62 Types of forceps or clips
65 Award in the advertising industry
66 Actor Martin
67 Spanish is
68 Prefix with mere or phase
69 Wise men
70 Blood examination commonly ordered by allergists (acronym)
71 Type of progenitor blood cell

Down
1 Actress Meryl
2 Arnold ___ malformation
3 Piece of cloth carried by a mechanic (2 wds)
4 Dangerous insect
5 Indian rule
6 Greek god of love
7 ___ is (2 wds)
8 Indicate
9 Old enough to enlist or be drafted
10 Famed Chinese leader
11 Ripping away, as of tissue
12 Marked enthusiasm
13 Types of hydrocarbons (suffix)
19 Walked upon
21 ___ she (2 wds)
25 Snick or ___
27 Groove used in joining wood pieces
29 Vacation objective, for some
30 Relating to sight
31 Dark-brown viscid product sometimes used by dermatologists
32 Chicago to Atlanta direction (abbr)
33 Dangerous disease affecting coagulation (abbr)
36 Certain type of tuna
37 Adam Vinatieri’s important asset (2 words)
38 Aware of (informally)
39 Pre-antibiotic ___
40 Military education program (abbr)
44 Stores, perhaps
46 Mouthful of tobacco (dialect)
48 ___ girl! (Obstetric exclamation, 2 words)
49 Strew with debris
50 Raises upright
51 Common place to put your 15-Across
52 Store grain in a tower
53 Adjust a camera lens again
56 Striped or large-mouth follower
57 Utah ski area
58 Santa ___ KP Northern California medical center
60 Scraps of food
63 “___Got a Secret”
64 Blood oxygen measurement, informally

Visit TPJ on the Web for answers to this puzzle: www.kp.org/permanentejournal

Kenneth J Berniker, MD, is a Board-certified Emergency Physician at the Vallejo Medical Center. He always enjoyed solving crossword and cryptic puzzles and now creates his own. The challenges in creating the puzzles include: completing the grid with usable answers and perhaps a theme, generating interesting clues of suitable difficulty, being error-free in framing questions and answers, and injecting humor. Have fun, and please send him your comments. E-mail: kenneth.berniker@kp.org.
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website: www.klcu.org
Keep It Off: Use the Power of Self-Hypnosis to Lose Weight Now—Book and 4-CD Set
by Brian Alman, PhD

In this excellent book and companion set of CDs, Dr. Brian Alman, PhD, discusses the foundation and techniques of self-hypnosis used to achieve and sustain weight loss. Dr. Alman has taught this material to obese patients at The Kaiser Permanente Positive Choice Wellness Center in San Diego. He now shares with us these self-hypnosis skills, which he learned as a student from his beloved teacher, the psychiatrist Milton Erickson.

As we have found in treating 24,000 obese patients in San Diego, weight gain is usually not the problem but is instead the solution to underlying problems rooted in the past. Overeating is usually caused not by physical appetite but by emotional need. As a normal response in childhood, people learn to associate food with comfort and protection. To successfully lose weight and keep it off, a person often must get to the root of his or her underlying problems; the relapse rate after fad dieting is so high because dieters' inability to address their repressed feelings. Permanent change in body weight often depends on successfully addressing these unconscious memories and understanding how they became part of our life. This success is followed naturally—and permanently—by success in keeping the weight off.

Dr. Alman's premise is that the simple secret to losing weight and keeping it off, a person often must get to the root of his or her underlying problems; the relapse rate after fad dieting is so high because of dieters' inability to address their repressed feelings. Permanent change in body weight often depends on successfully addressing these unconscious memories and understanding how they became part of our life. This success is followed naturally—and permanently—by success in keeping the weight off.

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Dr. Alman has given us a useful tool, both a stepwise approach for people with weight problems as well as a primer for therapists on how to effectively help people lose weight and keep it off. Dr. Alman supplies the part missing from most weight programs: a way to help patients cope with the emotional underpinnings of obesity.

Power

Ultimately, the only power to which man should aspire is that which he exercises over himself.

—Elie Wiesel, b 1928, Romanian-born American writer, 1986 Nobel Laureate for Peace
The Cutting Edge: A Newsletter for People Living With Self-Inflicted Violence
by Ruta Mazelis, Creator and Editor

The Cutting Edge: A Newsletter for People Living with Self-Inflicted Violence is published quarterly by Ruta Mazelis, who writes and consults on issues of trauma and self-injury and is committed to providing “a forum for [people] living with self-inflicted violence [SIV] and our allies.” Since 1990, Ms Mazelis has been publishing information about SIV from the perspective of those who live it. She speaks as a witness and describes her writing as “editorials.” Keeping this description in mind, readers of this newsletter can easily appreciate the value of Ms Mazelis’s commentary.

In its approach to borderline personality disorder (BPD) (the label typically affixed to people who self-injure), this publication differs greatly from peer-reviewed publications, such as those published by the National Institute of Mental Health, and perhaps in this difference lies the greatest value of the newsletter.

The Cutting Edge offers insight into a condition that is mystifying, disturbing, frustrating, and often misunderstood. For those of us who otherwise could not fathom what it is like to find relief in pain, the grassroots voice of The Cutting Edge brings alive the experience of being a self-injurer:

“This monstrous evil that lay within me
I have opened the incision
For all to come see …
Come all to my mirror …
The pain is now gone
The feeling has left
Gone is desire
Gone is my debt
I feel nothing right now.
—Anonymous”

In Ms Mazelis’ experience, “… rarely is SIV explored [by researchers] for the meaning and purpose it has in the person’s life. It is most often perceived to be a pathological behavior requiring whatever degree of intervention it takes to make it stop.” She asks, “Who are the experts?” and points out, “Oftentimes the ‘expertise’ of the person holding the opinion is based on formal credentialing … [which] is deemed more valuable than lived experience. This popular mentality is unfortunate, however, and is often used to invalidate the intuitive knowledge held by each person who lives with SIV.”

According to the National Institute of Mental Health, Borderline personality disorder (BPD) is a serious mental illness … While less well known than schizophrenia or bipolar disorder (manic-depressive illness), BPD is more common, affecting 2% of adults, mostly young women. There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases. Patients often need extensive mental health services, and account for 20% of psychiatric hospitalizations. Yet, with help, many improve over time and are eventually able to lead productive lives.

… Studies show that many, but not all individuals with BPD report a history of abuse, neglect, or separation as young children. Forty to 71% of BPD patients report having been sexually abused, usually by a non-caregiver. Researchers believe that BPD results from a combination of individual vulnerability to environmental stress, neglect or abuse as young children, and a series of events that trigger the onset of the disorder as young adults. Adults with BPD are also considerably more likely to be the victim of violence, including rape and other crimes. This may result from both harmful environments as well as impulsivity and poor judgment in choosing partners and lifestyles.

The Cutting Edge explores in the plainest possible terms the issues surrounding SIV, and Ms Mazelis clearly states her observations, including some particularly striking ones:

• Results of SIV research can be unreliable because such research is often sponsored by pharmaceutical companies with agendas that can create promedication bias.

• People with SIV come from all walks of life, ethnicities, and socioeconomic strata.

• Some of the existing “systems of care” that [perhaps inadvertently] judge, shame, [and] punish people with SIV actually revictimize instead of heal them.

• Victims of SIV are often more hopeful than are the professionals from whom these victims seek help.

Carol A Redding, MA, a writer, is also an Information Technology Consultant and Customer Service Manager at San Diego State University; a California-licensed Private Investigator; a grant writer for the California Institutes of Preventive Medicine; an authentic voice in the National Call to Action, a movement to end child abuse and neglect; and a Fellow of the Association of Teachers of Preventive Medicine.
SIV is arrested most successfully not when it is approached as the primary target but instead when efforts to help are undertaken as compassionate, collaborative work on the issues underlying SIV. For anyone confronted with the perplexing challenge of helping a person who lives with SIV, an especially useful item of information is that the most beneficial remedy for the affected person is a caring helper but not necessarily a professional one: “The process of healing SIV can be simply described—it is the process of healing the pain that brought about the need for SIV in the first place. … What is at the core of the healing process? Intimate connection … with their own historical realities, including the invalidations, abuses, and shaming in their pasts, in the presence of a compassionate person who is there to validate their truth and soothe the pain of awareness and grief. People who confront the roots of their pain, and identify the patterns of survival used to manage it, build a relationship with themselves that is based on dignity and self-compassion.”

The Cutting Edge includes book reviews as well as poignant writings and artwork by self-injurers. These contents offer remarkable insight into the foundation of the condition. In these writings, the reader is quickly led to see a common thread of abuse, exploitation, anger, shame, and distrust.

“My skin tells the story of the pain that I feel each scar holds an emotion that I didn’t reveal”

—Tiffany, 20, Self-Injurer for six years

References

Sweet Serenity
The love of learning, the sequestered nooks
And all the sweet serenity of books
—Henry Wadsworth Longfellow, 1807-1882, American poet
Rudolph’s Pediatrics, 21st edition
by Colin D Rudolph, Abraham M Rudolph, Margaret K Hostetter, George Lister, and Norman J Siegel, editors

At 2688 pages—the weight of a healthy, 13-pound infant—this pediatrics textbook is packed with information on all aspects of children’s health and disease. Using the expertise of a strong team of coeditors at Yale University, the Rudolph family continues a tradition of editorial excellence backed by more than 100 years of experience—the experience contained in 20 previous editions of this classic pediatric work.

The book is divided into 27 chapters covering normal childhood development and psychosocial issues, the pathology of every organ or body system, and topics that include immunology, rheumatology, infectious diseases, cancer, and metabolic disorders. The choice of associate editors and of nearly 500 contributors is a Who’s Who of the academic pediatrics world and assures that the quality of each chapter is uniformly well written, informative, and able to provide sufficient background information for the selected topic, both in content and in the amount of information provided.

The editors have performed superbly in assembling this information coherently and rationally. From my own particular point of reference as a pediatric endocrinologist, I found the endocrine section first-rate. A pediatric endocrine fellow would do well to put the topic into perspective by reading this section just before obtaining certification. This strategy applies to all other pediatric subspecialists.

In a book with so many contributors, duplication can be expected. After all, repetition is appropriate in this sort of reference book, which readers are likely to consult by chapter and thus may rightfully expect to be internally coherent. Such coherence may be expected, for example, in the six pages about biochemical diagnosis of inborn errors of metabolism which appear in the chapter positioned immediately before the 114-page chapter on metabolic disorders.

In contrast to the book’s many chapters on specialized topics, some general chapters (eg, Chapter 7, “Complex Decisions in Pediatric Care”) offer a brief, insightful account of topics that rarely receive the attention necessary in busy inpatient situations, where diagnostic and procedural activities occupy most of a physician’s time.

Thus, this publication is indeed an outstanding pediatric textbook despite the negative aspects inherent in all textbooks: being out of date (in this case, by three years); repeating topics (a feature inherent in nearly any book with multiplicity of topics and contributors); and only minimally mentioning important topics that are almost impossible to discuss extensively within given space limitations.

Rudolph’s Pediatrics definitely should be part of all reference libraries in medical schools and hospitals. However, in our changing times, use of this comprehensive textbook by practicing pediatricians would probably be directly related to the user’s age, which in turn is likely to reflect the user’s computer skills. I suspect that for senior pediatricians trained before the advent of the computer age, Rudolph’s will be the first reference used when the need for information arises. In contrast, younger physicians—whose clerkships almost certainly included use of computers linked to computer networks—may tend to turn first to the Internet for quick, convenient access to up-to-date information.
Pocket Radiologist: Chest: Top 100 Diagnoses
by Jud W Gurney, MD, Helen T Winer-Muram, MD

Review by Roxana Covali, MD

This wonderful book is appropriately dedicated to radiologists, pulmonary physicians, surgeons, and all physicians who use chest x-ray films and related images. Gurney’s Pocket Radiologist addresses the 100 most common radiologic diagnoses of the chest.

Most diagnoses are discussed in a structured, three-page format that includes key clinical facts, imaging findings, differential diagnosis, pathology, clinical issues, selected references, and two high-resolution images of the chest—one radiograph and one computed tomography (CT) image. For diagnoses that require more detailed explanation, the chest radiograph is replaced by a full-color, computer-generated image that clarifies relevant aspects of anatomy and pathology.

Key clinical facts are presented to illustrate and explain the diagnosis. Synonyms for the diagnosis also are listed. Imaging findings are presented with descriptions of general features expected to be seen on chest radiographs, CT and high-resolution CT (HRCT) scans, and magnetic resonance imaging (MRI) scans. Obstetric ultrasonograms are presented to show bronchial atresia in utero, and images made by using radioactive isotopes are included to illustrate goiter, extramedullary hematopoiesis, or toxic inhalation.

All findings from chest radiographs and CT scans are thoroughly discussed with specific and nonspecific features; percentage of common findings and complications; early radiographic manifestations; length of time to resolution; and recommendations for obtaining earlier imaging studies for comparison. The usefulness of other imaging techniques also is clearly explained. Each diagnosis is presented with recommendations for or against imaging—for example, whether to supplement chest radiography with CT studies to characterize a mass and its relation to surrounding structures.

Differential diagnoses are intelligently organized and are compared with the final diagnosis. Pathology subsections present pathogenesis; gross and microscopic pathology; and prevalence of abnormalities. Clinical issues discussed include disease presentation, natural history, treatment, and prognosis. For example, discussion of fungal pneumonia includes not only symptoms but also the geographic distribution and source of specific fungi. Treatment is clearly presented. Discussion of prognosis includes both median survival rate and mortality rate. Two or three selected references from major medical journals through 2002 are listed at the end of every diagnosis.

The book is well organized into 14 sections ranging from the airspace to the chest wall.

The Airspace section has 18 well-chosen diagnoses. Imaging findings are well detailed for pneumonia, fungal pneumonia, and in particular, for AIDS. The clinical presentation of eosinophilic lung disease is exceptionally well described as is the differential diagnosis of neurogenic pulmonary edema. The differential diagnosis and clinical presentation of viral pneumonia are thoroughly discussed. General pathologic findings in immunocompromised hosts are well described.

The Airways section nicely describes nine diseases, including tracheal disease (a commonly overlooked diagnosis). Other well-presented sections discuss imaging findings, differential diagnosis, and clinical issues in amyloidosis; imaging findings for bronchiectasis and cystic fibrosis; and disease of small airways.

The book carefully describes 14 types of interstitial disease: sarcoidosis, rheumatoid arthritis, Langerhans cell histiocytosis, asbestosis, and pneumoconiosis (from coal and silica). Helpful sections describe radiologic and clinical manifestations of drug reaction; lymphangitic carcinomatosis; systemic lupus erythematosus; and diffuse interstitial pneumonia.

The Mediastinum section describes diagnosis of 15 conditions, including mediastinal germ tumor, lymphoma (Hodgkin’s, non-Hodgkin’s, and posttransplant lymphoproliferative disorder), paraneoplastic syndromes, and nerve sheath tumors. Imaging findings and pathology are well detailed, especially for nerve sheath tumors.

The high-quality, appropriately selected images as well as the substantial amount of information about each diagnosis make this book both valuable and practical.

Roxana Covali, MD, is a radiologist at the Elena Doamna Obstetrics and Gynecology University Hospital in Iasi, Romania. She also assists in teaching histology at the Gr. T. Popa University of Medicine and Pharmacy in Iasi, Romania. E-mail: grcovali@telebit.ro.
An impressive chapter about carcinomas includes a subsection on each of three topics: lung cancer staging, missed diagnosis of lung cancer, and radiation therapy. The subsection on lung cancer staging discusses interpretation of CT findings; accuracy of CT-based staging; method of adrenal evaluation; the TNM method of staging; and survival rates in relation to staging. The authors emphasize that imaging findings should be confirmed surgically.

The subsection on missed diagnosis of lung cancer describes a hierarchy of errors and discusses overdiagnosis bias, National Cancer Institute (NCI) lung cancer detection programs, and the role of CT screening.

The section on nodules describes five diseases, including solitary pulmonary nodules (discussed most comprehensively). Imaging findings of metastases—especially patterns of metastases shown on chest radiographs—are explained clearly. Arteriovenous malformations are vividly illustrated by a digital subtraction angiogram.

The remaining sections also are well done: Pleura, which describes nine entities ranging from effusion to metastasis; Hyperinflation and cysts, in which alpha 1-antitrypsin deficiency is the most detailed of four diagnoses; Heart and pericardium, which includes calcifications and detecting abnormal position or displacement of pacemaker and defibrillator leads with perforation or infection; Pulmonary artery and Aorta sections, which discuss four entities, including aortic aneurysm and dissection; Trauma, which describes aortic transection, tracheobronchial rupture, and three other conditions; and a chapter which describes use of a portable ICU to treat any of four disease entities. Use of various tubes and catheters (endotracheal, nasogastric, tracheostomy, chest) in normal and abnormal situations is explained exceptionally well. The Chest wall section discusses five diagnoses.

My three small criticisms of this book are that it contains too many abbreviations; that the disease entities discussed in every chapter are not alphabetically ordered; and that it contains too little information on congenital heart malformation. Notwithstanding these minor criticisms, however, the book ends with a well-constructed, comprehensive index of diagnoses—and this useful feature can compensate substantially for the lack of alphabetic ordering of diagnoses within each chapter.

The high-quality, appropriately selected images as well as the substantial amount of information about each diagnosis make this book both valuable and practical. As a final touch, a CD-ROM is provided for conveniently transferring information (including some color illustrations) from the main text to a personal digital assistant (PDA) device.

The Habit of Reading

To acquire the habit of reading is to construct for yourself a refuge from almost all the miseries of life.

—W Somerset Maugham, 1874-1965, British novelist, playwright, and short-story writer
CME Evaluation Form

All PMG physicians and those clinicians eligible to do so may earn up to two hours of Category 1 credit for reading and analyzing the four designated CME articles, by selecting the most appropriate answer to the questions below, and by successfully completing the evaluation form. Please return (fax or mail to the address listed on the back of this form) to The Permanente Journal by June 30, 2004. You must complete all sections to receive credit. (Completed forms will be accepted until two months after receipt of form.)

The Permanente Journal has been approved by the American Academy of Family Physicians as having educational content acceptable for prescribed credit hours. Term of approval covers issues published within one year from the distribution date of May 2004. This Spring 2004 issue has been reviewed and is acceptable for up to two prescribed credit hours. Credit may be claimed for one year from the date of this issue.

Section A.

Article 1. Initiative to Improve Mammogram Interpretation

Relative to a general radiology practice, limiting the interpretation of mammograms to physicians specializing in mammography interpretation can be expected to increase the sensitivity for detection of breast cancer by about:
   a. 2%
   b. 5%
   c. 10%
   d. 20%

Recall rates for mammography can be lowered to at least what level without adversely impacting cancer detection rates:
   a. 7%
   b. 10%
   c. 15%
   d. 20%

Which is the incorrect statement? There is evidence that the perioperative briefing has:
   a. reduced wrong site surgery
   b. decreased nursing turnover
   c. decreased time to document records
   d. improved the perception of the Operating Room’s safety climate from “good” to “outstanding”

Article 2. Preoperative Safety Briefing Project

The preoperative safety briefing is an opportunity for members to share pertinent information regarding the patient’s care before and during the surgical procedure. Important elements of the briefing include creating a climate of:
   a. improved communication
   b. collaboration
   c. teamwork
   d. situational awareness
   e. intimacy

Which is the incorrect statement? There is evidence that the perioperative briefing has:
   a. reduced wrong site surgery
   b. decreased nursing turnover
   c. decreased time to document records
   d. improved the perception of the Operating Room’s safety climate from “good” to “outstanding”

Article 3. Factors Associated with Smoking Cessation Among Quit Smart™ Participants

Factors that increase relapse to smoking include:
   a. living and working with smokers
   b. quitting without Nicotine Replacement Therapy (NRT)
   c. quitting without behavioral counseling
   d. a and c
   e. a, b, and c

Clinicians should refer smokers for smoking cessation counseling for all of the reasons below, except:
   a. it increases 12-month abstinence rates
   b. it provides tools to change behaviors associated with smoking
   c. it is cost effective
   d. nicotine is a strongly addictive substance
   e. proof of program participation will decrease the member’s health insurance premium

(Continued on next page)
Article 4. Systems Learning from Physician Performance Data

If primary care physicians each manage their diabetic patients optimally, it is more likely that:
- a. patient satisfaction rates will be high
- b. ambulatory care costs will be below the mean
- c. cancer screening rates for eligible women will be high
- d. cancer screening and patient satisfaction rates will be high
- e. all other performance measures will be optimal

If a department chief identified several high-performing physicians, they would most likely be:
- a. from the smallest medical centers
- b. working full time
- c. new to the group
- d. in shared practices or with stable clinical teams
- e. those with high patient continuity

Section B.

Referring to the CME articles and to the stated objectives, please check the box next to each statement as appropriate.

<table>
<thead>
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<th>Article 1</th>
<th>Article 2</th>
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<td>Strongly Agree</td>
<td>Strongly Disagree</td>
<td>Strongly Agree</td>
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<td>5</td>
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The article covered the stated objectives. [ ] [ ] [ ] [ ]
I learned something new that was important. [ ] [ ] [ ] [ ]
I plan to use this information as appropriate. [ ] [ ] [ ] [ ]
I plan to seek more information on this topic. [ ] [ ] [ ] [ ]
I understood what the author was trying to say. [ ] [ ] [ ] [ ]

Section C.

What change(s), if any, do you plan to make in your practice as a result of reading these articles?

________________________________________________________________________
________________________________________________________________________
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Section D. (Please print)

Name: ______________________________________________
E-mail: ______________________________________________
Address: ______________________________________________
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The Myths of the Preventions-Only Visit
Patricia E. Broko, MD, MPH, A. Phyllis Lazear, MD

This article explores the current status of the health maintenance visit, including discussion of the expectations of both patients and health care providers.

Commentary

The Anatomy of Hope
Jacqueline Grosstein, MD

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