

Diagnostic Errors Estimated to Kill Between 40,000 and 80,000 Each Year

In the March 11 issue of the *Journal of the American Medical Association*, David Newman-Toker, M.D., Ph.D., and Peter Pronovost, M.D., Ph.D., of Johns Hopkins Medicine, report that misdiagnosis accounts for an estimated 40,000 to 80,000 hospital deaths per year and that tort claims for diagnostic errors — defined as diagnoses that are missed, wrong or delayed — are nearly twice as common as claims for medication errors.

Newman-Toker and Pronovost point out that bloodstream infections in intensive care units have decreased through systematic solutions adopted by hospitals, such as requiring physicians to follow a procedural checklist that emphasizes sterile techniques when inserting medical catheters.

The Johns Hopkins team suggests that diagnostic errors might be reduced by systematically adopting tools such as checklists that help physicians remember critical diagnoses or by making available computer programs known as “diagnostic decision-support systems” that assist physicians in calculating the level of risk of a given patient’s having certain diseases. Health systems could further decrease diagnostic errors, they say, with time-tested, low-tech tools such as independent second looks at X-rays and CT scans or rapidly directing patients with unusual symptoms to diagnostic experts.

“Right now there is often a mismatch between who gets advanced diagnostic testing and who needs it, leading to worse outcomes and higher costs. Realigning resources with needs could improve outcomes at lower cost,” says Newman-Toker, assistant professor of neurology with joint appointments in otolaryngology, health sciences informatics, epidemiology, and health policy and management at the Johns Hopkins University School of Medicine and the Johns Hopkins Bloomberg School of Public Health.

“The first step in addressing the diagnostic error problem is to shine a light on them so they are clearly visible,” Pronovost says. “Then with wise investments, clinicians, researchers and patients can discover how to prevent them.” Pronovost, a professor of anesthesiology, critical care medicine and surgery, is medical director of Johns Hopkins’ Center for Innovation in Quality Patient Care.

Doctors Seek Agreements that Patients Will Not Post Medical Experiences

The growing popularity of online physician ratings has prompted some doctors to begin requiring their patients to sign agreements stating they will not post negative comments online. Physician opposition to performance ratings is not new, but the increasing number of patients who are posting their medical experiences online has led doctors to take the unusual step of effectively seeking gag orders prohibiting patients from doing so.

Medical Justice, an organization that assists doctors in responding to medical malpractice lawsuits, is making available standardized waiver agreements for doctors to provide their patients. Patients who sign the agreements agree not post negative comments about their doctor online. If patients refuse to sign, they can be turned away by the physician.

Online consumer ratings for most businesses are a common expectation in today’s Internet driven society, leading some to argue that doctors are putting patients in the position of choosing between health care and their First Amendment rights.

Health Quiz

1. Diagnostic errors can be prevented with simple checklists.
(a) True
(b) False
2. Some doctors are attempting to block a patient from posting online comments about the physician’s performance.
(a) True
(b) False
3. Mandated medical loss ratios are helping lower the cost of health care.
(a) True
(b) False
4. According to a recent study, 89% of premium growth over a five year period was due to medical costs.
(a) True
(b) False
5. Health plan administrative costs can improve the quality of care an individual receives.
(a) True
(b) False

Why States Reject Mandatory Medical Loss Ratios

Medical Loss Ratio (MLR) is a term that refers to the percentage of dollars a health plan spends on medical care. MLRs, also referred to as benefit cost ratios and medical cost ratios, use the amounts a health plan spends on direct medical care and its administrative services to provide a general measure of the relationship between claims and premiums. MLRs do not, and were never intended to, measure the quality, efficiency, or performance of health plans.

As the cost of health coverage has risen, provider groups have sought to blame health plan administrative spending for the increase. Such an effort attempts to shift the focus away from the real cost driver – rising medical costs. A recent study by RAND Health revealed that 89 percent of premium growth over a five year period was due to increased medical costs, while only 11 percent was due to administrative expenses.

Administrative expenses entail far more than the costs of processing claims and overhead. Today's health plans provide an array of non-physician medical care such as 24-hour nurse hot lines, disease management, wellness and prevention programs, health education, and care management. Health plan administrative costs also include investments in health information technology, transparency initiatives, and fraud detection – all of which are designed to reduce costs, maintain affordability of coverage and increase the quality of the health care system. With research indicating that an estimated one-third of all medical spending in the U.S. is unnecessary, the role health plan administrative spending plays in increasing the efficiency of the health care system becomes apparent.

Most states have rejected mandatory MLRs because of their nominal effect on the cost of health coverage and the harm that can occur to consumers and the health care system if administrative spending is limited.

Medical Procedures Increasing Patients Exposure to Radiation

According to a recent report by the National Council on Radiation, Protection and Measurement (NCRPM), in 2006 Americans were exposed to seven times the amount of ionizing radiation from medical procedures than was the case in the early 1980s. The increase was primarily a result of growth in the use of medical imaging procedures.

A report from the Government Accounting Office in June 2008 found that between 2000 and 2006 Medicare spending for imaging services more than doubled to about \$14 billion. GAO's analysis showed trends linking spending growth to the increased use of imaging services in physicians' offices. Additionally they found that in-office imaging spending per beneficiary varied substantially across geographic regions of the country, suggesting that not all utilization was necessary or appropriate.

In addition to the increasing costs of the tests, questions regarding their medical appropriateness and the risk of overexposure have raised concerns. Radiation exposure has been clearly linked as a cause of cancer. The NCRPM report estimated that half of all exposure to radiation is currently from medical imaging.

An increase in the number of tests being performed on equipment owned by the referring physician raises additional questions about whether patients are receiving proper care or being unnecessarily exposed to radiation because of the financial incentives for the referring doctor.

A report released in 2008 by the Massachusetts Medical Society revealed that almost 30 percent of CT scans and MRI studies were liability concerns rather than medical necessity.

Trivia answers: 1. a (True) 2. a (True) 3. b (False) 4. a (True) 5. a (True)

Birthdays

April

2 – Rep. Delwin Jones
4 – Sen. Dan Patrick
4 – Rep. Craig Eiland
5 – Rep. Larry Phillips
6 – Rep. Rick Hardcastle
7 – Sen. Rodney Ellis
7 – Rep. Alma Allen
8 – Rep. Byron Cook
9 – Rep. Allen Fletcher
18 – Rep. Kristi Thibaut
20 – Rep. Jodie Laubenberg
21 – Rep. Helen Giddings
26 – Rep. Myra Crownover