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**1. Cost and Workforce Implications of Subjecting All Physicians to Aviation Industry Work-Hour Restrictions.**

Payette M, Chatterjee A, Weeks WB.  
Am J Surg. 2009(Jun); 197(6):820–825.

*This study sought to assess the hypothetical economic impact of applying aviation industry work-hour regulations to healthcare, apropos of ongoing debate about the efficacy of resident duty-hour restrictions as a means of improving patient and provider safety. Applying a mathematical model to physician salary and workforce data, the authors calculated that reducing residents' and physicians' work hours to aviation-industry levels would incur estimated annual costs of \$6.5 billion and \$80.4 billion respectively. They further calculated that the cost per life saved if such an intervention eliminated all deaths attributable to medical error would be between \$1.03 and \$2.07 million. Two tables and two figures are included.*

**2. Cost Implications of Reduced Work Hours and Workloads for Resident Physicians.**

Nuckols TK, Bhattacharya J, Wolman DM, Ulmer C, Escarce JJ.  
N Engl J Med. 2009(May 21); 360(21):2202–2215.

*This study assessed the costs and benefits of implementing recent Institute of Medicine recommendations concerning resident work hours, which would tighten the restrictions mandated by the Accreditation Council for Graduate Medical Education in 2003. The authors used data-based estimates and statistical modeling to assess the labor costs associated with hypothetical implementation of the IOM's recommendations as well the cost effectiveness of their implementation with respect to patient safety. They found that adoption of the IOM's recommendations would result in an estimated \$1.6 billion increase in annual labor costs. If effective in reducing preventable adverse events, implementation of the recommendations could represent cost savings for the general public, but the net costs to teaching hospitals of implementing such measures would be considerable. Multiple tables are included.*

**3. Cumulative Incidence of False-Positive Results in Repeated, Multimodal Cancer Screening.**

Croswell JM, Kramer BS, Kreimer AR, et al.  
Ann Fam Med. 2009(May/Jun); 7(3):212–222.

*Although screening for various cancer types is generally regarded as beneficial, negative consequences associated with false-positive results of screening tests can have a significant adverse impact on patients. To better understand the scope of this issue, this study sought to determine the cumulative frequency and impact of false-positive results among patients undergoing repeated, regular screening for four types of cancer as part of an ongoing randomized controlled trial. Results showed that the cumulative probability of a false-positive result increased with the number of screening tests and was approximately 50% after 14 screening tests; the probability of a patient's having an invasive diagnostic procedure associated with a false-positive result was greater than 20% after 14 tests. Results and implications of these findings are discussed. Three tables and three figures are included.*

- 4. Effects of Pay for Performance on the Quality of Primary Care in England.**  
Campbell SM, Reeves D, Kontopantelis E, Sibbald B, Roland M.  
N Engl J Med. 2009(Jul 23); 361(4):368–378.  
*This study assessed the impact of a pay-for-performance program implemented in 2004 on the quality of care delivered by family practices in England. The authors used an interrupted time-series analysis to compare quality of care related to three chronic conditions at multiple points before and after introduction of the incentives program. They found that quality improvement initially accelerated for two of the three conditions examined following implementation of the program, but that the rates of improvement later slowed. In addition, performance on some quality indicators not subject to incentives decreased during the study, as did patient-perceived continuity of care. Three tables and two figures are included.*
- 5. First, Make No Mistakes.**  
Hall J.  
New York Times. July 29, 2009:A23.  
*This op-ed piece argues that healthcare should follow the transportation industry’s approach to safety in order to address the persistent problem of medical errors. The author, a former chairman of the National Transportation Safety Board, suggests that establishment of an NTSB-like agency dedicated to monitoring and investigating healthcare errors could improve patient safety at minimal public cost.*
- 6. Found in Translation: Exporting Patient-Centered Communication and Small Group Teaching Skills to China.**  
Blatt B, Kallenberg G, Lang F, et al.  
Med Educ Online. 2009; 14(6).  
Available at: <http://www.med-ed-online.org>  
*This article reports on the development and implementation of a program designed to instruct Chinese physicians in Western-style provider-patient communication and “train the trainer” teaching techniques. The authors describe the structure and content of the program and comment on lessons learned during its implementation, in particular, the linguistic and cultural obstacles encountered and how they were overcome. One table and one figure are included.*

- 7. Global Measures of Quality- and Patient Safety-Related Childbirth Outcomes: Should We Monitor Adverse or Ideal Rates?**  
Gregory KD, Fridman M, Shah S, Korst LM.  
Am J Obstet Gynecol. 2009(Jun); 200(6):681.e1–681.e7.  
*This article describes the development and application of a hospital-level measure for assessing childbirth-related safety and quality of care. The new measure differs from existing adverse outcome indicators in that it quantifies complication-free (“ideal”) deliveries rather than those with complications. To illustrate application of the measure, the authors present data on childbirth complication rates and corresponding ID rates for 382,276 deliveries in California hospitals in 2002. The authors comment on their findings, the strengths and weaknesses of the ID-rate measure, and its potential as a source of information for both hospitals and patients/consumers. Three tables, one figure, and an appendix are included.*
- 8. Lateral Violence in the Perioperative Setting.**  
Bigony L, Lipke TG, Lundberg A, McGraw CA, Pagac GL, Rogers A.  
AORN Journal. 2009(Apr); 89(4):688–696.  
*Lateral violence in nursing, defined as bullying, intimidating, or otherwise antagonistic behavior among nurses in the workplace, occurs frequently and can undermine patient safety and quality of care. This article describes the circumstances in which lateral violence commonly takes place, discusses its negative effects on nurses’ well-being and on the safety and quality of care, and offers strategies for preventing or mitigating the impact of this behavior.*
- 9. Making Health Literacy Real: Adult Literacy and Medical Students Teach Each Other.**  
Hess J, Whelan JS.  
J Med Libr Assoc. 2009(Jul); 97(3):221–224.  
*This brief report describes the design, implementation, and outcomes of a collaborative educational workshop in which medical school students met with adult learners to explore techniques in health-related communication. One table is included.*
- 10. Management of Test Results in Family Medicine Offices.**  
Elder NC, McEwen TR, Flach JM, Gallimore JJ.  
Ann Fam Med. 2009(Jul/Aug); 7(4):343–351.  
*This exploratory study used mixed methods to examine management of patient test results in the physician practice setting. The authors conducted in-depth observations, staff interviews, and patient surveys at four physician practices in order to describe the results management processes in use. While specific procedures for test results management varied from clinic to clinic, the authors found that office staff and leadership’s “safety awareness” (espousal of safety-conscious attitudes and practices), as well as the presence and use of health IT applications, appeared to play an important role in promoting effective test results management. Three tables and one figure are included.*

- 11. Medication Errors Occurring in the Radiologic Services Department.**  
Pennsylvania Patient Safety Authority.  
Pa Patient Saf Advis. 2009(Jun); 6(2):46–50.  
Available at: [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Jun6\(2\)/Pages/46.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Jun6(2)/Pages/46.aspx)  
*This article presents a review and analysis of data on medication errors associated with radiologic procedures. The authors summarize data from published studies and present an analysis of events reported to Pennsylvania’s public reporting system, along with risk reduction strategies. Four tables are included.*
- 12. Participant Observation of Time Allocation, Direct Patient Contact and Simultaneous Activities in Hospital Physicians.**  
Weigl M, Müller A, Zupanc A, Angerer P.  
BMC Health Serv Res. 2009(Jun 29); 9(110).  
*This study explored the time allocations of physicians through direct observation of 35 surgeons and internists at a Southern Germany teaching hospital. The authors looked at two factors in particular that are of relevance to safety and quality of care: the amount of time spent in direct interaction with patients and the amount spent engaged in multiple simultaneous tasks. They found that physicians spent approximately one-fourth of their working hours in direct contact with patients, and nearly one-fifth of their time engaged in simultaneous activities. Further results, implications of these findings, and possibilities for further research in this area are discussed. Five tables are included.*
- 13. Patient Safety: Sixth Report of Session 2008–09.**  
House of Commons Health Committee. London, England: The Stationery Office Limited; July 3, 2009.  
Available at: <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151i.pdf>  
*This report evaluates National Health Service policy regarding patient safety and sets forth recommendations for improvement. Topics addressed include patient safety measurement and evaluation, disclosure and apology in the aftermath of a medical error, event reporting, patient safety at the front lines of care, technology, medical education and training, the role of regulatory bodies, and the role of governance.*
- 14. Reducing Diagnostic Error in Medicine—There’s a Job for Everyone.**  
Graber ML.  
Focus Patient Saf. 2009(Summer); 12(2):6–7.  
[http://npsf.org/paf/npsfp/fo/pdf/Focus\\_Volume\\_12\\_Issue\\_2.pdf](http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_12_Issue_2.pdf)  
*This article comments on the need for the medical community to focus greater attention on the problem of diagnostic error. The author notes that while physicians should assume the main responsibility for addressing this issue, all parties involved can play a role. To this end, he identifies steps that physicians, patients, healthcare organizations, and others can take to help improve diagnostic accuracy and reduce the risk of error.*

- 15. Shop for Quality or Volume? Volume, Quality, and Outcomes of Coronary Artery Bypass Surgery.**  
Auerbach AD, Hilton JF, Maselli J, Pekow PS, Rothberg MB, Lindenauer PK.  
Ann Intern Med. 2009(May 19); 150(10):696–704.  
*This study assessed the impact of case volume and of quality of care on patient outcomes in a large group of cardiac surgery patients in the US, and investigated whether one of these factors affected patient outcomes more strongly than the other. The authors examined the respective influence of hospital/surgeon case volumes and adherence to selected quality-of-care measures on postoperative mortality and readmission rates in a national sample of more than 81,000 patients who had undergone coronary bypass surgery during a 2-year period. They found that performance on quality measures was the factor most strongly predictive of patient outcomes, although a modest inverse association between volume and adverse outcomes was also observed. Five tables and one figure are included.*
- 16. The 5<sup>th</sup> Anniversary of the “Universal Protocol”: Pitfalls and Pearls Revisited.**  
Stahel PF, Mehler PS, Clarke TJ, Varnell J.  
Patient Saf Surg. 2009(Jul 1); 3(14).  
Available at: <http://www.pssjournal.com/content/3/1/14>  
*This article discusses the Joint Commission’s Universal Protocol for the prevention of wrong site surgery on the occasion of the fifth anniversary of its establishment in July 2004. The authors review recent findings on the incidence of wrong site surgery and discuss some of the challenges of applying the protocol, which, they suggest, may explain why implementation of the protocol has not successfully eliminated such errors. In light of these considerations, they offer detailed recommendations on correct interpretation and application of the protocol to maximize its benefit to patient safety. One figure is included.*
- 17. The Risks of Inappropriateness in Cardiac Imaging.**  
Picano E.  
Int J Environ Res Public Health. 2009(May); 6(5):1649–1664.  
Available at: <http://www.mdpi.com/1660-4601/6/5/1649/pdf>  
*This article calls attention to the issue of excessive or inappropriate use of cardiac imaging tests, which can expose patients to unnecessary clinical risks and financial burdens. The author reviews data from multiple published sources concerning the relative risks and benefits associated with various cardiovascular imaging tests and the frequency with which tests are performed inappropriately. He urges practitioners to exercise vigilance to ensure appropriate use and maximum benefit of such tests to patients. Multiple tables and figures are included.*

- 18. Using Personal Health Records to Improve the Quality of Health Care for Children.**  
Council on Clinical Information Technology.  
Pediatrics. 2009(Jul); 124(1):403–409.  
Available at: <http://www.pediatrics.org/cgi/content/full/124/1/403>  
*This article presents a policy statement from the American Academy of Pediatrics concerning the development and adoption of personal health records (PHRs) in pediatric care. The statement identifies establishment of data standards and development of incentives for adoption as critical needs that must be met in order for the potential benefits of PHRs to be realized.*
- 19. What Can Aviation Teach Health Care about Consumers' Role in Safety?**  
Porto G.  
Focus Patient Saf. 2009(Summer); 12(2):3–5.  
Available at: [http://npsf.org/paf/npsfp/fo/pdf/Focus\\_Volume\\_12\\_Issue\\_2.pdf](http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_12_Issue_2.pdf)  
*This article comments on a recent aviation incident involving a passenger plane forced to make an emergency landing in the Hudson River, in which all passengers and crew members survived with only a few people suffering serious injuries. The author argues that, while media coverage has focused on the technical skill and heroism of the plane's captain, the passengers' observance of safety practices also played a significant role in this seemingly miraculous outcome. Drawing an analogy between airline customers and healthcare consumers, the author then discusses the lessons that can be derived from this incident about the role of patients in improving healthcare safety.*
- 20. Working Conditions in Primary Care: Physician Reactions and Care Quality.**  
Linzer M, Manwell LB, Williams ES, et al., for the MEMO (Minimizing Error, Maximizing Outcome) Investigators.  
Ann Intern Med. 2009(July 7); 151(1):28–36.  
*This study assessed the relationships among work environment, physicians' job-related satisfaction and well-being, and quality and safety of care in a cross-sectional group of primary care practices. The authors surveyed physicians from 119 family practices in New York City and the upper Midwest and analyzed medical records for a sample of patients at each practice. Results of a correlational analysis indicated that physician-reported adverse working conditions were strongly linked to physician dissatisfaction, stress, and burnout. While associations were found between certain workplace factors and rates of error and/or quality of care, the strength of these associations varied; no association was found between physician reactions and quality of care or rates of error. Five tables and one figure are included.*

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