



CUSTOMER FOCUSED HEALTH CARE DELIVERY AND SATISFACTION October 2003

Am J Manag Care. 2003 Aug;9(8):564-71.

Patient-provider discussions about conflicts of interest in managed care:
physicians' perceptions.

Gorawara-Bhat R, Gallagher TH, Levinson W.

Department of Medicine, University of Chicago, Ill, USA.

BACKGROUND: Patients worry about financial conflicts of interest related to cost containment but may hesitate to share this concern with their physician. Little is known about how this issue affects encounters between doctors and patients, or about the communication strategies physicians endorse for responding to such concerns. **OBJECTIVE:** To understand physicians' perspectives on how managed care patients' concerns about conflicts of interest are impacting the physician-patient relationship in routine visits. **STUDY DESIGN:** Qualitative analysis of physician focus groups. Physicians also rated audiotaped dialogues of different communication strategies for discussing conflicts of interest with patients. **PARTICIPANTS:** Thirty-nine community physicians (25 general internists and 14 family practice physicians) in Portland, Oregon--a highly penetrated managed care market. Physicians' average age was 44 years; 36% were women.

RESULTS: These physicians report that patient concern about financial conflicts of interest is implicit in many patient encounters. However, patients rarely ask directly about conflicts of interest. Physicians believe that patients' concerns about conflicts of interest are impairing doctor-patient relationships and damaging physicians' sense of professional worth. Physicians prefer communication strategies for discussing conflicts of interest that address patients' emotions or identify a common goal through negotiation. These physicians seldom initiate discussions with patients about conflicts of interest. **CONCLUSIONS:** Patient concern about conflicts of interest is adversely impacting the physician-patient interaction. Physicians should be alert to patients' implicit expressions of concern about conflicts of interest, and practice communication techniques for responding to these concerns effectively. PMID: 12921234 [PubMed - indexed for MEDLINE]

Am J Nurs. 2003 Sep;103(9):47.

Mercy in the room. Interview by Sylvia Foley.
Levine S.

Publication Types:

Interview

PMID: 14506806 [PubMed - indexed for MEDLINE]

Am J Orthod Dentofacial Orthop. 2003 Aug;124(2):138-43.

Health-related quality of life and psychosocial function 5 years after orthognathic surgery.

Motegi E, Hatch JP, Rugh JD, Yamaguchi H.

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This prospective, multisite, randomized clinical trial evaluated the long-term health-related quality of life and psychosocial function of 93 patients after bilateral sagittal split osteotomy to correct Class II malocclusion. Patients were evaluated approximately 2 weeks before surgery, and 2 and 5 years after surgery. Scores from the Sickness Impact Profile psychosocial dimension and all of its components showed significant improvement from presurgery to 2 and 5 years postsurgery ($P < .05$). The overall dimension score also showed significant improvement ($P < .05$). Change between 2 and 5 years postsurgery was not significant, demonstrating that the improvement was stable between 2 and 5 years. The Oral Health Status Questionnaire showed significant improvement at 2 and 5 years relative to presurgery ($P < .05$). These improvements also remained stable between 2 and 5 years, with the exception of general oral health. The Symptom Checklist 90 Revised demonstrated significant improvements from presurgery to 2 and 5 years after surgery ($P < .05$) in all areas except somatization. Results other than somatization did not change significantly between 2 and 5 years, showing that improvements were stable. The 7-point satisfaction scale showed that patients were satisfied with postsurgical results, and their satisfaction was maintained 5 years after surgery. It is concluded that general health-related quality of life, oral health-related quality of life, and psychosocial function show significant improvements after bilateral sagittal split osteotomy, and the improvements are stable between 2 and 5 years after surgery.

Publication Types:

Clinical Trial

Multicenter Study

Randomized Controlled Trial

PMID: 12923507 [PubMed - indexed for MEDLINE]

Am J Phys Med Rehabil. 2003 Sep;82(9):692-9; quiz 700-1, 715.

Effect of functional gain on satisfaction with medical rehabilitation after stroke.

Tooth LR, Ottenbacher KJ, Smith PM, Illig SB, Linn RT, Gonzales VA, Granger CV. School of Population Health, University of Queensland, Brisbane, Australia.

OBJECTIVE: To examine the association between gain in motor and cognitive functional status with patient satisfaction 3-6 mo after rehabilitation discharge. DESIGN: Patient satisfaction and changes in functional status were examined in 18,375 patients with stroke who received inpatient medical rehabilitation. Information was obtained from 144 hospitals and rehabilitation facilities contributing records to the Uniform Data System for Medical Rehabilitation and the National Follow-up Services. RESULTS: Data analysis revealed significant ($P < 0.05$) differences in satisfaction responses based on whether information was collected from patient self-report or from a family member proxy, and the two subsets were analyzed separately. Logistic regression revealed the following significant predictors of satisfaction for data collected from stroke patients: cognitive and motor gain, rehospitalization, who the patient was living with at follow-up, age, and follow-up therapy. In the patient-reported data subset, compared with patients who showed improved cognitive or motor functional status, those with no change, respectively, had a

31% and 33% reduced risk of dissatisfaction. In addition, rehospitalized patients had a higher risk of dissatisfaction. For the proxy reported data subset, significant influences on satisfaction were health maintenance, rehospitalization, stroke type, ethnicity, cognitive FIM gain, length of stay, and follow-up therapy. CONCLUSIONS: Ratings of satisfaction with rehabilitation services were affected by change in functional status and whether the information was collected from patient rating or proxy response. PMID: 12960911 [PubMed - indexed for MEDLINE]

Am J Public Health. 2003 Sep;93(9):1484-9.

Health, supportive environments, and the Reasonable Person Model.

Kaplan S, Kaplan R.

Department of Psychology, University of Michigan, Ann Arbor, MI 48109, USA.

The Reasonable Person Model is a conceptual framework that links environmental factors with human behavior. People are more reasonable, cooperative, helpful, and satisfied when the environment supports their basic informational needs. The same environmental supports are important factors in enhancing human health. We use this framework to identify the informational requirements common to various health-promoting factors that are realizable through well-designed physical environments. Environmental attractors, support of way-finding, and facilitation of social interaction all contribute to the health-relevant themes of community, crime, and mode of transportation. In addition, the nearby natural environment, although often neglected, can serve as a remarkably effective resource.

PMID: 12948967 [PubMed - indexed for MEDLINE]

Am J Public Health. 2003 Sep;93(9):1379-80; author reply 1380.

Comment on:

Am J Public Health. 2002 Nov;92(11):1748-55.

Healthy communities: a natural ally for community-oriented primary care.

Cashman SB, Stenger J.

Publication Types:

Comment

Letter

PMID: 12948943 [PubMed - indexed for MEDLINE]

Ann Emerg Med. 2003 Sep;42(3):317-23.

The left-without-being-seen patients: what would keep them from leaving?

Arendt KW, Sadosty AT, Weaver AL, Brent CR, Boie ET.

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STUDY OBJECTIVE: We determine which services, if any, an emergency department (ED) could provide to help a patient who left the ED without being seen by a physician wait longer to see a physician. METHODS: In this retrospective observational study, patients who had left the Saint Marys Hospital ED without being seen by a physician were surveyed by telephone. The Saint Marys Hospital ED is a 43-bed facility with an annual patient volume of 77600 located in a city of 82000. Responders were questioned regarding 15 specific services the Saint Marys Hospital ED could provide to help them wait longer. Eligible participants included willing adults, parents accompanying patients younger than 18 years of age, and patients between the ages of 13 and 18 years whose parents granted permission. Participants were excluded if they denied research authorization, did not speak English, refused to participate, or were unable to be contacted.

RESULTS: Between April 9, 2001, and July 17, 2001, 20494 patients registered, 172 patients left without being seen, and 152 patients approved research authorization; we attempted to contact these patients. In total, 97 patients, their parents, or their caretakers completed the entire interview (56.4% of those who left without being seen, 63.8% of those with whom contact was attempted). Nearly 85% of responders retrospectively identified "more frequent updates on wait time" and 70.1% identified "the availability of immediate temporary treatments" as services that would have helped them wait longer. Other waiting room services were identified by fewer than half of the responders as potentially helpful in allowing them to wait longer. CONCLUSION: Communication of estimated waiting time and the availability of immediate treatments for minor injuries or symptoms might increase the time patients are willing to wait and therefore might decrease an ED's rate of patients leaving without being seen. PMID: 12944882 [PubMed - indexed for MEDLINE]

Ann Intern Med. 2003 Sep 2;139(5 Pt 2):403-9.

Ten recommendations for advancing patient-centered outcomes measurement for older persons.

McHorney CA.

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The past 50 years have seen great progress in the measurement of patient-based outcomes for older populations. Most of the measures now used were created under the umbrella of a set of assumptions and procedures known as classical test theory. A recent alternative for health status assessment is item response theory. Item response theory is superior to classical test theory because it can eliminate test dependency and achieve more precise measurement through computerized adaptive testing. Computerized adaptive testing reduces test administration times and allows varied and precise estimates of ability. Several key challenges must be met before computerized adaptive testing becomes a productive reality. I discuss these challenges for the health assessment of older persons in the form of 10 "Ds": things we need to deliberate, debate, decide, and do.

Publication Types:

Review

Review Literature

PMID: 12965966 [PubMed - indexed for MEDLINE]

Ann Intern Med. 2003 Sep 2;139(5 Pt 2):410-5.

Measuring and improving the quality of dying and death.

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Improving end-of-life experience is a major challenge to successful aging. Deaths that are reasonably free of discomfort, in accordance with patients' wishes, and within acceptable professional and ethical standards are high-quality deaths. The authors developed a 31-item measure of the quality of dying and death and applied it in a community sample and a sample of hospice enrollees. Scores on the Quality of Dying and Death Instrument and measures of perceived quality of care were collected from patients' loved ones after death. Higher overall after-death ratings of the quality of care received from all providers and from physicians were associated with higher-quality dying and death. How well patients' symptoms were controlled in the community study and how well wishes were followed and treatments were explained in the hospice study

were associated with higher-quality dying. Major challenges to end-of-life research include recruiting representative population samples, given widespread reluctance of patients and loved ones to participate in research at the end of life; important variation in evaluations among different reporters after death; reluctance of loved ones to assign negative evaluations to dying experiences after death; and the highly individual and dynamic nature of dying experiences. Overcoming these challenges is of great importance in the search for the social, organizational, and individual determinants of high-quality dying in the U.S. cultural and health care context.

Publication Types:

Review

Review Literature

PMID: 12965967 [PubMed - indexed for MEDLINE]

Ann Intern Med. 2003 Sep 2;139(5 Pt 1):384.

Death rituals.

Lerman R.

William Beaumont Hospital, Imaging Center, Royal Oak, MI 48073-6769, USA.

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PMID: 12965949 [PubMed - indexed for MEDLINE]

Ann R Coll Physicians Surg Can. 2001 Oct;34(7):441-3.

In long-term care, the "R" in CPR is not for resurrection.

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Objective: To determine whether the concept of the "R" in CPR (cardiopulmonary resuscitation) not meaning resurrection as opposed to resuscitation is a useful explanation to families of patients in long-term care why CPR may not be recommended. Methods: A review of the relevant literature and such ideas as futility was used to develop the conceptual basis for the discussion.

Conclusion: There is enough evidence to support the position that for the frail, elderly, long-term care patient, the concept of resurrection rather than resuscitation can be a useful explanation to families why CPR should not be attempted in most circumstances.

PMID: 12962084 [PubMed - indexed for MEDLINE]

ANS Adv Nurs Sci. 2003 Jul-Sep;26(3):227-37.

Empowerment as treatment and the role of health professionals.

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This article argues that the concept of empowerment has been co-opted by health professionals and redefined as an intervention to produce compliance. Patients are considered empowered by health professionals only if they make the correct choices as defined by the health care provider. Patients are not informed about all possible choices and are not free to make their own choices for their own reasons. Empowerment is a coercive strategy that is justified by its outcomes and creates dependent populations.

PMID: 12945657 [PubMed - indexed for MEDLINE]

Bangladesh Med Res Counc Bull. 2002 Dec;28(3):87-96.

Quality of health care from patient perspectives.

Rahman MM, Shahidullah M, Shahiduzzaman M, Rashid HA.

Planning Commission, Ministry of Planning, Dhaka.

The quality of health care is the consequence of strong link between service providers and user of the services. Perceived quality is one of the principal determinant of utilisation and non-utilisation of health services, a major issue in developing countries. Considering this, the present study was aimed to assess the quality of care in in-patient and outpatient departments of rural and urban government hospitals in Bangladesh. A total of 2420 patients were interviewed. The patients were selected by using systematic random sampling technique. Results revealed that age, waiting time, time spent for patient examination, place of treatment, income, years of schooling and male sex appeared to be independent predictors of patient satisfaction ($p < 0.001$). Age, waiting time and years of schooling were negatively related with level of satisfaction indicating younger patients, less waiting time and patients with less education were more satisfied, whereas time spent for examination, income were positively related with patient's satisfaction. Patients attending at the urban hospitals and male sex were also significantly associated with patient's satisfaction. The study recommends that both short and long-term policy action should be adopted for quality assurance of the existing health care facilities in Bangladesh.

PMID: 14509380 [PubMed - indexed for MEDLINE]

Bioethics. 2002 Aug;16(4):335-52.

Patients' responsibilities in medical ethics.

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Patients have not been entirely ignored in medical ethics. There has been a shift from the general presumption that 'doctor knows best' to a heightened respect for patient autonomy. Medical ethics remains one-sided, however. It tends (incorrectly) to interpret patient autonomy as mere participation in decisions, rather than a willingness to take the consequences. In this respect, medical ethics remains largely paternalistic, requiring doctors to protect patients from the consequences of their decisions. This is reflected in a one-sided account of duties in medical ethics. Duties fall mainly on doctors and only exceptionally on patients. Medical ethics may exempt patient from obligations because they are the weaker or more vulnerable party in the doctor-patient relationship. We argue that vulnerability does not exclude obligation. We also look at other ways in which patient responsibilities flow from general ethics: for instance, from responsibilities to others and to the self, from duties of citizens, and from the responsibilities of those who solicit advice. Finally, we argue that certain duties of patients counterbalance an otherwise unfair capacity of doctors as helpers.

PMID: 12956177 [PubMed - indexed for MEDLINE]

Bioethics Forum. 2002;18(1-2):7-14.

Moral distress or moral comfort.

Corley MC, Minick P.

Moral distress in healthcare results from a professional's inability to provide compassionate care to patients because of individual, organizational, or societal barriers. Research suggests that moral distress is a growing concern

among nurses, and may be a major reason why nurses leave one job for another or abandon the profession of nursing. Some professionals, however, have identified strategies that help them work through their moral distress toward an experience of moral comfort. These strategies may be individual, organizational, or societal. The focus of this paper is to identify examples of strategies professionals have used to alleviate distressful feelings and enhance moral comfort.

PMID: 12956166 [PubMed - indexed for MEDLINE]

Bioethics Forum. 2002;18(1-2):24-9.

In the patient's best interest--a call to action, a call to balance.

Hirsch NJ.

Nurses, physicians, and other healthcare professionals often complain that a loss of freedom or other obstacles hinder their ability to act in the best interest of the patient. These barriers cause professional burnout and moral outrage, and may contribute to a migration away from medicine or, more broadly, healthcare. Understanding the historical underpinnings of the phrase "in the patient's best interest," and realizing that healthcare, which is fundamentally a moral enterprise must be built on sound business principles can help healthcare professionals reframe the issue, and reclaim their original commitment to a difficult path.

PMID: 12956171 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):745-8.

Strategies to help patients understand risks.

Paling J.

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PMID: 14512489 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):741-4.

Simple tools for understanding risks: from innumeracy to insight.

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PMID: 14512488 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):691-2.

Communicating risks.

Edwards A.

Publication Types:

Editorial

PMID: 14512448 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):692-3.

The role of risk communication in shared decision making.

Godolphin W.

Publication Types:

Editorial

PMID: 14512449 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):703-9.

Effects of communicating individual risks in screening programmes: Cochrane systematic review.

Edwards A, Unigwe S, Elwyn G, Hood K.

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OBJECTIVE: To assess the effects of different types of individualised risk communication for patients who are deciding whether to participate in screening. DESIGN: Systematic review. DATA SOURCES: Specialist register of the Cochrane consumers and communication review group, scientific databases, and a manual follow up of references. SELECTION OF STUDIES: Studies were randomised controlled trials addressing decisions by patients whether or not to undergo screening and incorporating an intervention with an element of "individualised" risk communication-based on the individual's own risk factors for a condition (such as age or family history). OUTCOME MEASURES: The principal outcome was uptake of screening tests; further cognitive and affective measures were also assessed to gauge informed decision making. RESULTS: 13 studies were included, 10 of which addressed mammography programmes. Individualised risk communication

was associated with an increased uptake of screening tests (odds ratio 1.5, 95% confidence interval 1.11 to 2.03). Few cognitive or affective outcomes were reported consistently, so it was not possible to conclude whether this increase in the uptake of tests was related to informed decision making by patients.

CONCLUSIONS: Individualised risk estimates may be effective for purposes of population health, but their effects on increasing uptake of screening programmes may not be interpretable as evidence of informed decision making by patients. Greater attention is required to ways of developing interventions for screening programmes that can achieve this.

Publication Types:

Review

Review, Academic

PMID: 14512475 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 13;327(7415):581.

Patients put their relationship with their doctors as second only to that with their families.

Pincock S.

Publication Types:

News

PMID: 12969915 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 13;327(7415):614-5.

Doctors should not discuss resuscitation with terminally ill patients: FOR.

Manisty C, Waxman J.

Department of Cancer Medicine, Faculty of Medicine, Imperial College of Science, Technology and Medicine, Hammersmith Campus, London W12 0NN.

PMID: 12969934 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 13;327(7415):615-6.

Doctors should not discuss resuscitation with terminally ill patients: AGAINST.
Higginson JJ.
Department of Palliative Care and Policy, King's College London, Weston
Education Centre, London SE5 9RJ. irene.higginson@ kcl.ac.uk
PMID: 12969935 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 6;327(7414):542-5.
The importance of patient preferences in treatment decisions--challenges for
doctors.
Say RE, Thomson R.
Medical School, University of Newcastle upon Tyne, Newcastle upon Tyne NE2 4HH.
Publication Types:
 Review
 Review Literature
PMID: 12958116 [PubMed - indexed for MEDLINE]

Br J Gen Pract. 2003 Jun;53(491):490-1.
Patients' attitudes to GPs' use of computers.
Chan W, McGlade K.
Publication Types:
 Letter
PMID: 12939902 [PubMed - indexed for MEDLINE]

Can HIV AIDS Policy Law Rev. 2003 Apr;8(1):5-6.
Transparency, participation, and accountability.
[No authors listed]
Publication Types:
 Editorial
 Newspaper Article
PMID: 12924288 [PubMed - indexed for MEDLINE]

Can Oper Room Nurs J. 2001 Jun;19(2):21-5.
Dealing with difficult people.
Keenan-Hayes S.
Inpatient Psychiatric Unit, Queensway-Carlton Hospital, Ottawa.
PMID: 14509027 [PubMed - indexed for MEDLINE]

Cancer. 2003 Sep 1;98(5):885-7.
Informing patients with cancer of "new findings" that may influence their
willingness to participate in research studies.
Markman M.
Department of Hematology/Medical Oncology, The Cleveland Clinic Foundation,
Cleveland, OH 44195, USA. markmam@ccf.org
PMID: 12942552 [PubMed - indexed for MEDLINE]

CMAJ. 2003 Sep 2;169(5):405-12.
How does direct-to-consumer advertising (DTCA) affect prescribing? A survey in
primary care environments with and without legal DTCA.
Mintzes B, Barer ML, Kravitz RL, Bassett K, Lexchin J, Kazanjian A, Evans RG,

Pan R, Marion SA.

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BACKGROUND: Direct-to-consumer advertising (DTCA) of prescription drugs has increased rapidly in the United States during the last decade, yet little is known about its effects on prescribing decisions in primary care. We compared prescribing decisions in a US setting with legal DTCA and a Canadian setting where DTCA of prescription drugs is illegal, but some cross-border exposure occurs. **METHODS:** We recruited primary care physicians working in Sacramento, California, and Vancouver, British Columbia, and their group practice partners to participate in the study. On pre-selected days, patients aged 18 years or more completed a questionnaire before seeing their physician. We asked these patients' physicians to complete a brief questionnaire immediately following the selected patient visit. By pairing individual patient and physician responses, we determined how many patients had been exposed to some form of DTCA, the frequency of patients' requests for prescriptions for advertised medicines and the frequency of prescriptions that were stimulated by the patients' requests. We measured physicians' confidence in treatment choice for each new prescription by asking them whether they would prescribe this drug to a patient with the same condition. **RESULTS:** Seventy-eight physicians (Sacramento n = 38, Vancouver n = 40) and 1431 adult patients (Sacramento n = 683, Vancouver n = 748), or 61% of patients who consulted participating physicians on pre-set days, participated in the survey. Exposure to DTCA was higher in Sacramento, although 87.4% of Vancouver patients had seen prescription drug advertisements. Of the Sacramento patients, 7.2% requested advertised drugs as opposed to 3.3% in Vancouver (odds ratio [OR] 2.2, 95% confidence interval [CI] 1.2-4.1). Patients with higher self-reported exposure to advertising, conditions that were potentially treatable by advertised drugs, and/or greater reliance on advertising requested more advertised medicines. Physicians fulfilled most requests for DTCA drugs (for 72% of patients in Vancouver and 78% in Sacramento); this difference was not statistically significant. Patients who requested DTCA drugs were much more likely to receive 1 or more new prescriptions (for requested drugs or alternatives) than those who did not request DTCA drugs (OR 16.9, 95% CI 7.5-38.2). Physicians judged 50.0% of new prescriptions for requested DTCA drugs to be only "possible" or "unlikely" choices for other similar patients, as compared with 12.4% of new prescriptions not requested by patients (p < 0.001). **INTERPRETATION:** Our results suggest that more advertising leads to more requests for advertised medicines, and more prescriptions. If DTCA opens a conversation between patients and physicians, that conversation is highly likely to end with a prescription, often despite physician ambivalence about treatment choice. PMID: 12952801 [PubMed - indexed for MEDLINE]

CMAJ. 2003 Sep 2;169(5):425-7.

Direct-to-consumer prescription drug advertising in Canada: permission by default?

Gardner DM, Mintzes B, Ostry A.

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PMID: 12952804 [PubMed - indexed for MEDLINE]

CMAJ. 2003 Sep 2;169(5):381, 383.

Ads and prescription pads.

[Article in English, French]

[No authors listed]

Publication Types:

Editorial

PMID: 12952788 [PubMed - indexed for MEDLINE]

Coll Antropol. 2003 Jun;27(1):301-7.

Attitudes of medical staff towards the psychiatric label "schizophrenic patient" tested by an anti-stigma questionnaire.

Filipic I, Pavicic D, Filipic A, Hotujac L, Begic D, Grubisin J, Dordevic V.

Department of Psychiatry, University Hospital Center Zagreb, Croatia.

The aim of this research was to investigate the opinions and attitudes of medical staff towards schizophrenic patients. The research included three groups of examinees, 200 physicians of various specialties, 200 nurses and technicians working in Zagreb city hospitals, and 200 3rd and 4th year students of the School of Medicine in Zagreb. Previously validated anti-stigma questionnaire was used, consisting of 25 questions divided into three thematic groups, structured and adapted to the specific requirements of this study. The results were mutually compared and statistically analyzed by applying the chi 2-test. Significant difference ($p < 0.01$) between the answers of physicians and those of medical students was found in questions 2, 4, 5, 6, 11, 13, 15, 16, 18, 22, 23, 25, and between physicians and nurses/technicians in answers to questions 4, 15, 22, 23. Significant difference ($p < 0.01$) between the answers given by nurses/technicians and medical students was found in questions 10, 13, 22, 23. The results point to the existence of prejudices and stigmatizing attitudes in all three investigated groups. The most frequent reasons for stigmatizing attitude of students are based on fear and insufficient knowledge about mental patients and schizophrenia as a disease, while there are a high percentage of positive answers to the questions on rehabilitation and resocialization. The nurses/technicians also show a high degree of mistrust towards schizophrenic patients and mostly answer with "I don't know", thus presenting insufficiently formed attitudes about the mentioned problems. The physicians in their answers confirm fear, mistrust and stigmatizing attitudes towards schizophrenic patients found in general population in Croatia. The consequences of such attitudes are the low quality of life of schizophrenic patients, and slow, often incomplete, resocialization.

PMID: 12974160 [PubMed - indexed for MEDLINE]

Crit Care Nurs Q. 2003 Jul-Sep;26(3):214-20.

Spirituality in critical care: patient comfort and satisfaction.

Nussbaum GB.

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Creating an environment of compassion where patients feel that their emotional and spiritual needs are met is at the heart of holistic care. Patient satisfaction surveys address this powerful aspect of care and nurses find themselves in the position of making an impact. The nurse is at the bedside when crisis occurs, both physical and spiritual. Superficial attention to matters of spirituality is no longer acceptable. Nurses need to examine spirituality within themselves and be available when the patients give the invitation to join them in the struggle for peace. The critical care unit is most vulnerable because the intensity of illness is so great. Conscious or unconscious, the patient needs human touch and consolation, which transcends technology. Indifference to this

is all but negligence on the part of the nurse. Addressing this through careful care planning and joining the "fellowship of pain" brings the nurse into the healing process. "Burnout" decreases as care increases, and nurses experience the healing process themselves as well.

Publication Types:

Review

Review, Tutorial

PMID: 12930036 [PubMed - indexed for MEDLINE]

Dis Manag Advis. 2003 Jul;9(7):93-6.

Use exercise as a primary defense against chronic disease.

[No authors listed]

PMID: 12920784 [PubMed - indexed for MEDLINE]

Fla Nurse. 2001 Mar;49(1):27.

Nearly half of all women 65 and older use herbal products to feel better, but don't tell their doctors.

Yoon SJ.

PMID: 14508971 [PubMed - indexed for MEDLINE]

Hastings Cent Rep. 2001 Nov-Dec;31(6):26-33.

Trust and the ethics of health care institutions.

Goold SD.

Though trust is essential to relationships between people, including that between patient and clinician, its role in organizational ethics is largely unexplored. Nonetheless, trust is also ideally a part of the relationship between patient and health care institution, both because it is desirable in and of itself, and because it makes for better medical care.

PMID: 12945452 [PubMed - indexed for MEDLINE]

Health Care Food Nutr Focus. 2002 Jun;18(10):10-1.

Improving customer service. You are up to bat!

Dahl M.

PMID: 12974106 [PubMed - indexed for MEDLINE]

Health Care Food Nutr Focus. 2002 May;18(9):1, 3-5.

Four rules to guide customer service.

Johnson JE.

Georgetown University Hospital, Washington, D.C., USA.

PMID: 12974101 [PubMed - indexed for MEDLINE]

Health Care Manag (Frederick). 2003 Jul-Sep;22(3):265-74.

Patient-physician e-mail: passion or fashion?

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This article surveys the nature, prevalence, and risks and benefits of patient-physician e-mail as a prelude to critically evaluating what will be required for it to become a truly transformational technology. Diverse materials from both the popular press and various clinical domains are consulted in order

to appraise patient-physician e-mail's efficacy in different contexts and among different patient and physician users. Early evidence that patient-physician e-mail has lasting power includes its use in niche clinical applications, appearance of unsolicited patient e-mail, historical patterns of medical technology adoption, and increasing use of the Internet in general. Patient-physician e-mail will become genuinely transformational if it affirmatively improves the patient-physician encounter, contributes to better clinical outcomes, makes patient-physician communication more convenient for both parties, demonstrably transcends existing reimbursement and medicolegal concerns, and promotes patient empowerment. Like all technologies, use and misuse of patient-physician e-mail will determine whether its possibilities will become realities.

Publication Types:

Review

Review, Tutorial

PMID: 12956229 [PubMed - indexed for MEDLINE]

Health Care Manag (Frederick). 2003 Jul-Sep;22(3):275-81.

Consumers devise drug cost-cutting measures: medical and legal issues to consider.

Ganguli G.

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Health care costs in general, and prescription drug costs in particular, are rapidly rising. Between 1996 and 2007 the average annual per capita health care cost is projected to increase from dollar 3,781 to dollar 7,100. [AQ1] The single leading component of health care cost is the cost of prescription drugs (currently 10% of total health care spending, projected to become 18% in 2008). The average cost per drug increased 40% during the 1993-1998 period. Forty-one million Americans have no health insurance, and those who have, have inadequate prescription drug coverage. [AQ2] To cope with this situation, many consumers are trying to economize by doing without the prescriptions or the appropriate doses, buying generics or medicines from Canada or Mexico, or splitting pills of higher doses to take advantage of the pricing policy of drug manufacturers. Some of these approaches are medically and/or legally acceptable, while some are dubious. Most adversely affected are the seniors and poor; for certain groups of seniors prescription drugs account for 30% of their health care spending. The problem must receive prompt concerted attention from consumers, insurers, pharmaceutical companies, and lawmakers before it gets out of hand.

PMID: 12956230 [PubMed - indexed for MEDLINE]

Health Care Manage Rev. 2003 Jul-Sep;28(3):254-64.

Do appealing hospital rooms increase patient evaluations of physicians, nurses, and hospital services?

Swan JE, Richardson LD, Hutton JD.

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This article investigates the effects of appealing hospital rooms on patient evaluations of hospital services. A field study contrasting appealing and typical rooms finds that appealing rooms result in more positive patient evaluations of physicians and nurses, as well as more favorable patient judgments of the service.

PMID: 12940347 [PubMed - indexed for MEDLINE]

Health Serv J. 2003 Aug 21;113(5869):28-9.
Communications. The object of the exercise.
Howarth K, Imich J.
King's College Hospital Trust.
PMID: 12953393 [PubMed - indexed for MEDLINE]

Healthplan. 2003 Jul-Aug;44(4):29-30.
Creating the new health care consumer. An interview with David Lansky. Interview
by Ed Rabinowitz.
Lansky D.
Publication Types:
Interview
PMID: 12920867 [PubMed - indexed for MEDLINE]

Hosp Peer Rev. 2003 Sep;28(9):124-6.
Patient satisfaction depends on staff morale.
[No authors listed]
PMID: 12953366 [PubMed - indexed for MEDLINE]

Hosp Peer Rev. 2003 Sep;28(9):123-4.
Proven techniques to boost patient satisfaction.
Zimmermann PG.
pollyzimmermann@msn.com
PMID: 12953365 [PubMed - indexed for MEDLINE]

Integr Cancer Ther. 2003 Mar;2(1):5-12.
Healing the mind/body split: bringing the patient back into oncology.
Greer S.
St. Raphael's Hospice, London Road, North Cheam, Sutton, Surrey SM3 9DX, United
Kingdom.
The effect on oncology of the doctrine of Cartesian dualism is examined. It is
argued that (1) this doctrine continues to exert a baneful (though
unacknowledged) influence on the practice of oncology, (2) Descartes's doctrine
of a mind/body split is mistaken, and (3) mind and body (brain) are inextricably
interwoven. A biopsychosocial model of disease is advocated. The role of
psychooncology in healing the mind/body split by focusing research attention on
the patient is outlined.
Publication Types:
Review
Review, Tutorial
PMID: 12941164 [PubMed - indexed for MEDLINE]

Integr Cancer Ther. 2003 Mar;2(1):39-62.
Breaking bad news.
Block KI, Bugno TJ, Collichio FA, Geffen J, Schapira L.
Institute for Integrative Cancer Research and Education, 1800 Sherman Ave.,
Suite 515, Evanston, IL 60201, USA. research@blockmedical.com
PMID: 12941167 [PubMed - indexed for MEDLINE]

Iowa Med. 2003 Jul-Aug;93(4):22.
Gifts from patients--CEJA provides guidance.
Freeman J.
PMID: 12971237 [PubMed - indexed for MEDLINE]

IRB. 2002 Jul-Aug;24(4):6-8.
Pilot study: does the white coat influence research participation?
Merz JF, Rebbeck TR, Sankar P, Meagher EA.
Department of Medical Ethics, University of Pennsylvania School of Medicine,
USA.
PMID: 13678029 [PubMed - indexed for MEDLINE]

J Am Med Womens Assoc. 2003 Summer;58(3):131-2; author reply 132.
Comment on:
 J Am Med Womens Assoc. 2003 Spring;58(2):117-9.
Patient preference and provider gender.
Donohoe M.
Publication Types:
 Comment
 Letter
PMID: 12948101 [PubMed - indexed for MEDLINE]

J Biomed Inform. 2002 Oct-Dec;35(5-6):313-21.
Developing, implementing, and evaluating decision support systems for shared
decision making in patient care: a conceptual model and case illustration.
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The importance of including patient preferences in decisions regarding their
care has received increased emphasis over recent years. Medical informatics can
play an important role in improving patient-centered care by developing decision
support systems to support the inclusion of patient preferences in clinical
decision making. However, development of such systems is a complex task that
requires the integration of knowledge from four major research areas: (1) the
clinical domain, for understanding of the decision problem, (2) decision science
and research on shared decision making, to provide the theoretical underpinnings
and techniques for eliciting patient preferences; (3) medical informatics, to
provide the technology and algorithms for the collection, processing, structure,
presentation and integration of patient preferences into patient care; and (4)
organizational knowledge, to adapt the decision support system to the practices
and work flows of clinicians and the organizational and professional context of
the clinical practice settings. This paper describes a conceptual model
comprising eight key components that are important to be considered in the
development, implementation, and evaluation of decision support systems for
shared decision making in patient care. The example of CHOICE, a decision
support system to assist nurses in eliciting and integrating rehabilitation
patients' preferences for functional performance in patient care is used to
illustrate the eight components.
PMID: 12968780 [PubMed - indexed for MEDLINE]

J Clin Psychiatry. 2003 Jul;64(7):799-806.

Suggested guidelines for e-mail communication in psychiatric practice.

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BACKGROUND: Physicians and patients are increasingly communicating with one another by e-mail concerning administrative issues, medications, and other aspects of care. The objective of this article is to review existing guidelines for general physicians communicating with patients by e-mail as the basis for developing more specific guidelines for psychiatric practice. **METHOD:** We review e-mail guidelines previously developed by the American Medical Informatics Association, subsequently promulgated by the American Medical Association, and consider each suggestion for clinical and administrative practice from the perspective of psychiatric practice. Case vignettes illustrate several of these issues. **RESULTS:** We suggest expansion and/or modification of existing guidelines to address more directly issues of specific concern in psychiatric practice.

CONCLUSION: Existing general guidelines concerning the use of e-mail in medical practice are useful starting points for psychiatric practice. Psychiatrists must pay particular attention to issues of confidentiality, communicative tone, and professional boundaries. With cautious application, e-mail may provide a useful tool for enhancing communication and treatment options for psychiatrists and their patients.

PMID: 12934981 [PubMed - indexed for MEDLINE]

J Dent Educ. 2003 Aug;67(8):909-15.

Patient perceptions of professionalism in dentistry.

Brosky ME, Keefer OA, Hodges JS, Pesun IJ, Cook G.

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The purpose of this study was to examine how patients perceived the professionalism of University of Minnesota School of Dentistry students, faculty, and staff. Professionalism is defined by the authors as an image that will promote a successful relationship with the patient. Patients within comprehensive care clinics were asked to assess physical attributes and behaviors of the dental care providers using a questionnaire. The patients read statements dealing with characteristics of the dental care providers and responded as to whether they agreed, were neutral, or disagreed with the statement. The surveyed population consisted of 103 males and 97 females, 64 percent of whom lacked insurance coverage. Fifty-one percent of the patients were between the ages of forty-four and sixty-nine, but the overall age distribution was dispersed over a range of eighteen to one hundred. Our research found that all dental care providers displayed a professional appearance as well as behavior. The attire of the dental care provider affected the comfort and anxiety levels of patients, as did first impressions of both students and faculty. Most patients reported that students and faculty displayed effective time management and used appropriate language during the appointment. Finally, hairstyle, makeup, and jewelry appeared to have little effect on patients' opinions of the various dental care providers.

PMID: 12959165 [PubMed - indexed for MEDLINE]

J Dent Res. 2003 Sep;82(9):669-70.

Picture talk-effective communication with participants as a critical element in

oral health research.

Dale BA, Brown PS, Wells NJ.

Publication Types:

Editorial

PMID: 12939346 [PubMed - indexed for MEDLINE]

J Health Care Finance. 2003 Fall;30(1):65-71.

Health care consumer reports: an evaluation of consumer perspectives.

Longo DR, Everet KD.

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There has been a proliferation of health care consumer reports, also known as "consumer guides," "report cards," and "performance reports," which are designed to assist consumers in making more informed health care decisions. While there is evidence that providers use such reports to identify and make changes in practice, thus improving the quality of care, there is little empirical evidence on how consumer guides/report cards are used by consumers. This study fills that gap by surveying 925 patients as they wait for ambulatory care in several clinics in a midwestern city. Findings indicate that consumers are selective in their use of these reports and quickly identify those sections of the report of most interest to them. Report developers should take precautions to ensure such reports are viewed as credible sources of health care information.

Publication Types:

Evaluation Studies

PMID: 12967245 [PubMed - indexed for MEDLINE]

J Health Care Poor Underserved. 2003 Aug;14(3):351-71.

Medicaid managed care and racial differences in satisfaction and access.

Greenberg G, Brandon WP, Schoeps N, Tingle LR, Shull LD.

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Many researchers have suggested that the implementation of managed care may lower access to, and quality of, health care services for minorities. However, very little empirical data examining this issue exists. To examine it, the authors used a study design that was both cross-sectional and longitudinal in that they surveyed Medicaid recipients in two counties at two points in time; one of the counties began delivering services through managed care between the two survey periods. Their results indicate that, overall, managed care had neither a positive nor a negative effect on African Americans' access to health care services in either absolute terms or relative to whites'. In addition, race was not found to be associated with satisfaction. However, a Medicaid recipient's race was found to negatively affect his or her access to service under both managed care and fee-for-service systems.

Publication Types:

Evaluation Studies

PMID: 12955916 [PubMed - indexed for MEDLINE]

J Healthc Prot Manage. 2003 Summer;19(2):84-91.

Hostile encounters.

Tuthill DW.

Mayo Clinic Hospital, Phoenix, AZ, USA.

Understanding why patients act in a hostile manner is the first step in defusing a potentially violent situation and preventing injury to the patient and the security officer who may be called on to intervene.

PMID: 12921018 [PubMed - indexed for MEDLINE]

J Med Assoc Thai. 2003 Jun;86 Suppl 2:S338-43.

Factors related to patient satisfaction regarding spinal anesthesia.

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PURPOSE: Regional anesthesia has been shown to improve the clinically oriented outcome and many studies investigating the use of regional anesthesia have incorporated patient satisfaction measurements. This study was undertaken to find the factors related to patient satisfaction after spinal anesthesia which is the most frequent regional anesthesia conducted. **METHOD:** A prospective descriptive study of spinal anesthesia and post-operative survey of patients on the day after surgery was conducted by collecting pre-operative and intra-operative data on a constructed questionnaire. Post-operative data including average pain score, satisfaction score of receiving spinal anesthesia, adverse effects and willingness to accept or refuse spinal anesthesia for a similar surgery again were asked by the performer of spinal anesthesia or trained anesthesia personnel. **RESULTS:** The average satisfaction score of receiving spinal anesthesia of 522 patients was 8.30 +/- 1.80 which was divided into 502 (96.2%) of satisfied patients (satisfaction score > or = 5) and 20 (3.8%) of dissatisfied patients (satisfaction score < 5). Factors associated with dissatisfaction were the increasing number of attempts of spinal block, $p = 0.028$, OR = 0.67 (0.48-0.96); pain during spinal block, $p = 0.035$, OR = 0.77 (0.60-0.98), inadequate analgesia, $p = 0.005$, OR = 0.07 (0.01-0.45) and post-operative urinary retention, $p < 0.001$, OR = 0.07 (0.02-0.28). Factors associated with refusal to have spinal anesthesia for similar surgery again were: female gender, $p = 0.008$, OR = 6.00 (1.61-22.37), low body weight, $p = 0.009$, OR = 0.95 (0.92-0.98), intra-operative vomiting, $p = 0.01$, OR = 5.02 (1.47-17.08) and low satisfaction score of spinal anesthesia, $p < 0.001$, OR = 0.04 (0.01-0.12). **CONCLUSION:** The patients receiving spinal anesthesia gave a high rate of patient satisfaction score of receiving spinal anesthesia. Ensuring quality of spinal anesthesia, improving clinical skill of anesthesiologists and prevention of side effects especially urinary retention would improve patient satisfaction.

PMID: 12930008 [PubMed - indexed for MEDLINE]

J Natl Cancer Inst. 2003 Aug 20;95(16):1188-90.

Scrutinizing quality measures: people generally satisfied with quality of cancer care.

Christensen D.

Publication Types:

News

PMID: 12928338 [PubMed - indexed for MEDLINE]

J Nurs Adm. 2003 Sep;33(9):478-85.

The relationship between nurse staffing and patient outcomes.

Sasichay-Akkadechanunt T, Scalzi CC, Jawad AF.

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OBJECTIVES: To examine the association between in-hospital mortality and four nurse staffing variables-the ratio of total nursing staff to patients, the

proportion of RNs to total nursing staff, the mean years of RN experience, and the percentage of nurses with bachelor of science in nursing degrees.

BACKGROUND: Studies suggest that nurse staffing changes affect patient and organizational outcomes, but the impact of nurse staffing on patient outcomes has not been studied sufficiently and the results of the previous studies are equivocal. Additionally, the studies of the relationship between nurse staffing and patient outcomes or the impact of nurse staffing on patient outcomes had not been previously examined in Thailand.

METHODS: A retrospective, cross-sectional, observational research design was employed to study the research questions. Data of 2531 patients admitted to seven medical units and 10 surgical units of a 2300-bed university hospital in Thailand was used. All data of patients admitted to this hospital with four common groups of principal diagnoses (diseases of the heart, malignant neoplasms [cancer of all forms], hypertension and cerebrovascular diseases, and pneumonia and other diseases of the lung) was extracted from patient charts and discharge summaries in the calendar year 1999. Nurse staffing variables for each nursing unit in 1999 came from nursing service department databases. Multivariate logistic regression was used to determine the relationship between nurse staffing variables and in-hospital mortality.

RESULTS: The findings of this study revealed that the ratio of total nurse staffing to patients was significantly related to in-hospital mortality in both partial and marginal analyses, controlling for patient characteristics. In addition, the ratio of total nursing staff to patients was found to be the best predictor of in-hospital mortality among the four nurse staffing variables, controlling for patient characteristics. The study did not find any significant relationship between in-hospital mortality and three nurse staffing variables (the proportion of RNs to total nursing staff, the mean years of RN experience, and the percentage of bachelor degree prepared nurses) probably due to the low variation of these variables across nursing units or because they may have correlated with other variables.

CONCLUSIONS: The findings of this study add to our understanding of the importance of nurse staffing and its relationship to the patient outcome of hospital mortality. Further, the findings also provide information for hospital and nursing administrators to use when restructuring the clinical workforce, revising hospital policies, or making contractual decisions on behalf of nursing and public beneficiaries.

PMID: 14501564 [PubMed - indexed for MEDLINE]

J Nurs Adm. 2003 Sep;33(9):434-6.

Nurse caring behaviors and patient satisfaction: improvement after a multifaceted staff intervention.

Yeakel S, Maljanian R, Bohannon RW, Coulombe KH.

General Surgery Unit, Hartford Hospital, CT 06102, USA.

Publication Types:

Evaluation Studies

PMID: 14501558 [PubMed - indexed for MEDLINE]

J Psychosoc Nurs Ment Health Serv. 2003 Aug;41(8):28-36.

Use of a values history in approaching medical advance directives with psychiatric patients.

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The Patient Self-Determination Act became federal law in 1990. However, many

psychiatric facilities are just beginning to actively address the issue of medical advance directives. The term advance directives, for the purposes of this article, refers exclusively to medical advance directives. Psychiatric advance directives, which are related to issues such as involuntary hospitalization, are beyond the scope of this article.
PMID: 13677009 [PubMed - indexed for MEDLINE]

J Vasc Surg. 2003 Sep;38(3):626-7.
The surgeon's obligations to the noncompliant patient.
Jones JW, McCullough LB, Richman BW.
Department of Surgery, University of Missouri Columbia, MO 65212, USA.
jonesjw@health.missouri.edu
PMID: 12947291 [PubMed - indexed for MEDLINE]

J Wound Care. 2001 Oct;10(9):355-60.
Living with a chronic leg ulcer: an insight into patients' experiences and feelings.
Douglas V.
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OBJECTIVES: This study sought to ascertain patient need and help health-care professionals to understand the effects of chronic leg ulceration from a patient's perspective. METHOD: A qualitative grounded theory approach was used. A purposeful sample of eight participants (six females and two males) was selected. All were under the care of a district nurse and had over a year's history of venous leg ulceration. Data were collected by interview. RESULTS: Five major categories developed, relating to the 'physical experience', 'loss of control', 'vision of the future', 'carer's perspective' and 'health-care professional and patient relationship'. CONCLUSION: Although the physical and psychological effects of leg ulceration featured prominently in this study, these were heavily influenced by the relationship between the participant and the health-care professional.
PMID: 12964280 [PubMed - indexed for MEDLINE]

JAMA. 2003 Oct 8;290(14):1899-905.
Safety of patients isolated for infection control.
Stelfox HT, Bates DW, Redelmeier DA.
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CONTEXT: Hospital infection control policies that use patient isolation prevent nosocomial transmission of infectious diseases, but may inadvertently lead to patient neglect and errors. OBJECTIVE: To examine the quality of medical care received by patients isolated for infection control. DESIGN, SETTING, AND PATIENTS: We identified consecutive adults who were isolated for methicillin-resistant Staphylococcus aureus colonization or infection at 2 large North American teaching hospitals: a general cohort (patients admitted with all diagnoses between January 1, 1999, and January 1, 2000; n = 78); and a disease-specific cohort (patients admitted with a diagnosis of congestive heart failure between January 1, 1999, and July 1, 2002; n = 72). Two matched controls were selected for each isolated patient (n = 156 general cohort controls and n = 144 disease-specific cohort controls). MAIN OUTCOME MEASURES: Quality-of-care measures encompassing processes, outcomes, and satisfaction. Adjustments for study cohort and patient demographic, hospital, and clinical characteristics

were conducted using multivariable regression. RESULTS: Isolated and control patients generally had similar baseline characteristics; however, isolated patients were twice as likely as control patients to experience adverse events during their hospitalization (31 vs 15 adverse events per 1000 days; $P < .001$). This difference in adverse events reflected preventable events (20 vs 3 adverse events per 1000 days; $P < .001$) as opposed to nonpreventable events (11 vs 12 adverse events per 1000 days; $P = .98$). Isolated patients were also more likely to formally complain to the hospital about their care than control patients (8% vs 1%; $P < .001$), to have their vital signs not recorded as ordered (51% vs 31%; $P < .001$), and more likely to have days with no physician progress note (26% vs 13%; $P < .001$). No differences in hospital mortality were observed for the 2 groups (17% vs 10%; $P = .16$). CONCLUSION: Compared with controls, patients isolated for infection control precautions experience more preventable adverse events, express greater dissatisfaction with their treatment, and have less documented care.

PMID: 14532319 [PubMed - indexed for MEDLINE]

JAMA. 2003 Sep 3;290(9):1157-65.

Comment in:

JAMA. 2003 Sep 3;290(9):1210-2.

Effect of communications training on medical student performance.

Yedidia MJ, Gillespie CC, Kachur E, Schwartz MD, Ockene J, Chepaitis AE, Snyder CW, Lazare A, Lipkin M Jr.

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CONTEXT: Although physicians' communication skills have been found to be related to clinical outcomes and patient satisfaction, teaching of communication skills has not been fully integrated into many medical school curricula or adequately evaluated with large-scale controlled trials. OBJECTIVE: To determine whether communications training for medical students improves specific competencies known to affect outcomes of care. DESIGN AND SETTING: A communications curriculum instituted in 2000-2001 at 3 US medical schools was evaluated with objective structured clinical examinations (OSCEs). The same OSCEs were administered to a comparison cohort of students in the year before the intervention. PARTICIPANTS: One hundred thirty-eight randomly selected medical students (38% of eligible students) in the comparison cohort, tested at the beginning and end of their third year (1999-2000), and 155 students in the intervention cohort (42% of eligible students), tested at the beginning and end of their third year (2000-2001). INTERVENTION: Comprehensive communications curricula were developed at each school using an established educational model for teaching and practicing core communication skills and engaging students in self-reflection on their performance. Communications teaching was integrated with clinical material during the third year, required clerkships, and was supported by formal faculty development. MAIN OUTCOME MEASURES: Standardized patients assessed student performance in OSCEs on 21 skills related to 5 key patient care tasks: relationship development and maintenance, patient assessment, education and counseling, negotiation and shared decision making, and organization and time management. Scores were calculated as percentage of maximum possible performance. RESULTS: Adjusting for baseline differences, students exposed to the intervention significantly outperformed those in the comparison cohort on the overall OSCE (65.4% vs 60.4%; 5.1% difference; 95% confidence interval [CI], 3.9%-6.3%; $P < .001$), relationship development and maintenance (5.3% difference; 95% CI, 3.8%-6.7%; $P < .001$), organization and time

management (1.8% difference; 95% CI, 1.0%-2.7%; P<.001), and subsets of cases addressing patient assessment (6.7% difference; 95% CI, 5.9%-7.8%; P<.001) and negotiation and shared decision making (5.7% difference; 95% CI, 4.5%-6.9%; P<.001). Similar effects were found at each of the 3 schools, though they differed in magnitude. CONCLUSIONS: Communications curricula using an established educational model significantly improved third-year students' overall communications competence as well as their skills in relationship building, organization and time management, patient assessment, and negotiation and shared decision making-tasks that are important to positive patient outcomes. Improvements were observed at each of the 3 schools despite adaptation of the intervention to the local curriculum and culture.
PMID: 12952997 [PubMed - indexed for MEDLINE]

Mark Health Serv. 2003 Fall;23(3):28-32.
The satisfaction score.
Powers TL, Bendall-Lyon D.
University of Alabama at Birmingham, USA. tpowers@uab.edu
PMID: 12958748 [PubMed - indexed for MEDLINE]

Mark Health Serv. 2003 Fall;23(3):50-1.
Putting patients first.
Paddison N.
nanpadd@aol.com
PMID: 12958752 [PubMed - indexed for MEDLINE]

Med Care. 2003 Sep;41(9):1058-64.
Trust and satisfaction with physicians, insurers, and the medical profession.
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BACKGROUND: Conceptual or theoretical analysts of trust in medical settings distinguish among markedly different objects or types of trust. However, little is known about how similar or different these types of trust are in reality and the relationship of trust with satisfaction. OBJECTIVES: This exploratory study conducted a comparison among trust in one's personal physician, health insurer, and in the medical profession, and examined whether the relationship between trust and satisfaction differs according to the type of trust in question. RESEARCH DESIGN: Random national telephone survey using validated multi-item measures of trust and satisfaction. SUBJECTS: A total of 1117 individuals aged 20 years and older with health insurance and reporting 2 healthcare professional visits in the past 2 years. RESULTS: Rank-order correlation analyses find that both physician and insurer trust are sensitive to the amount of contact the patient has had and their adequacy of choice in selecting the physician or insurer. Trust in the medical profession stands out as being uniquely related to patients' desire to seek care and their preference for how much control physicians should have in making medical decisions. Adding satisfaction to the models reduced the number of significant predictors of insurance trust disproportionately. CONCLUSIONS: Consistent with theory, we found both substantial similarities and notable differences in the sets of factors that predict 3 different types of trust. Trust and satisfaction are much less distinct with respect to health insurers than with respect to physicians or the medical profession.

PMID: 12972845 [PubMed - indexed for MEDLINE]

Med Care. 2003 Sep;41(9):1048-57.

A randomized trial of two quality improvement strategies implemented in a statewide public community-based, long-term care program.

Kinney ED, Kennedy J, Cook CA, Freedman JA, Lane KA, Hui SL.

Center for Law and Health, Indiana University School of Law-Indianapolis, Indianapolis, Indiana 46202, USA. ekinney@iupui.edu

BACKGROUND: It has not been demonstrated that the implementation of computerized

quality improvement strategies can improve client-centered outcomes in public community based, long-term care (CBLTC) programs. OBJECTIVES: To test and evaluate 2 innovative computer-assisted, client-centered quality improvement strategies for public community-based, long-term care. The first strategy, the Normative Treatment Planning (NTP) program, assesses needs, prescribes services, and evaluates outcomes. The second strategy, the Client Feedback System (CFS) program, provides service vendors with feedback on client perceptions of services. RESEARCH DESIGN: A 2 x 2 factorial design with the 2 strategies using cluster randomization. SUBJECTS: A total of 2222 clients (86% of eligible program clients) enrolled in Indiana's state case management program and/or the Medicaid home and community-based services waiver program for the aged and disabled as of January 1, 1995. MEASURES: Outcomes of needs met and client satisfaction were measured through telephone surveys every 6 months for 2 years. RESULTS: A total of 1006 participants (45%) completed the 2-year evaluation study. For the group using only the NTP program, perception of needs met and client satisfaction were significantly better than the control group over the 2 years. During this period, the group using only the CFS program had significantly better client satisfaction than the control group. However, the effect sizes of the significant differences were small, and no statistically significant effects were found for the group using both programs. CONCLUSIONS: Client-centered quality improvement strategies can be implemented to enable public CBLTC programs to meet client needs better and increase client satisfaction.

Publication Types:

Clinical Trial

Randomized Controlled Trial

PMID: 12972844 [PubMed - indexed for MEDLINE]

Med Care. 2003 Sep;41(9):1096-109.

Nurse staffing models as predictors of patient outcomes.

McGillis Hall L, Doran D, Baker GR, Pink GH, Sidani S, O'Brien-Pallas L, Donner GJ.

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BACKGROUND: Little research has been conducted that examined the intended effects of nursing care on clinical outcomes. OBJECTIVE: The objective of this study was to evaluate the impact of different nurse staffing models on the patient outcomes of functional status, pain control, and patient satisfaction with nursing care. RESEARCH DESIGN: A repeated-measures study was conducted in all 19 teaching hospitals in Ontario, Canada. SUBJECTS: The sample comprised hospitals and adult medical-surgical and obstetric inpatients within those hospitals. MEASURES: The patient's functional health outcomes were assessed with

the Functional Independence Measure (FIM) and the Medical Outcome Study SF-36. Pain was assessed with the Brief Pain Inventory and patient perceptions of nursing care were measured with the nursing care quality subscale of the Patient Judgment of Hospital Quality Questionnaire. RESULTS: The proportion of regulated nursing staff on the unit was associated with better FIM scores and better social function scores at hospital discharge. In addition, a mix of staff that included RNs and unregulated workers was associated with better pain outcomes at discharge than a mix that involved RNs/RPNs and unregulated workers. Finally, patients were more satisfied with their obstetric nursing care on units where there was a higher proportion of regulated staff. CONCLUSIONS: The results of this study suggest that a higher proportion of RNs/RPNs on inpatient units in Ontario teaching hospitals is associated with better clinical outcomes at the time of hospital discharge.
PMID: 12972849 [PubMed - indexed for MEDLINE]

Med Care Res Rev. 2003 Sep;60(3):347-65.
A paradigm shift in patient satisfaction assessment.
Otani K, Harris LE, Tierney WM.
Indiana University-Purdue University, Fort Wayne, USA.
The authors investigated the relationships between patients' reactions to health care attributes and their overall satisfaction with primary care. The study found the following: (1) patients' overall satisfaction levels are disproportionately influenced by low levels of their reactions (less satisfied) to the primary care attribute, rather than simply averaged out among attribute reactions. This is a noncompensatory relationship. (2) The marginal impact of primary care attributes on overall satisfaction decreases at higher levels of patients' reactions (more satisfied) to primary care attributes, indicating a nonlinear relationship. Patients combine their reactions to the health care attributes by means of noncompensatory and nonlinear models to form their overall satisfaction. Decision makers should selectively concentrate training resources on those areas of attributes showing high dissatisfaction rather than attempt to improve an attribute that showed the largest parameter estimate. This approach would not only save resources but result in better outcomes of patient satisfaction.
PMID: 12971233 [PubMed - indexed for MEDLINE]

Med Decis Making. 2003 Jul-Aug;23(4):281-92.
Validation of a decision regret scale.
Brehaut JC, O'Connor AM, Wood TJ, Hack TF, Siminoff L, Gordon E, Feldman-Stewart D.
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BACKGROUND: As patients become more involved in health care decisions, there may be greater opportunity for decision regret. The authors could not find a validated, reliable tool for measuring regret after health care decisions. METHODS: A 5-item scale was administered to 4 patient groups making different health care decisions. Convergent validity was determined by examining the scale's correlation with satisfaction measures, decisional conflict, and health outcome measures. RESULTS: The scale showed good internal consistency (Cronbach's alpha = 0.81 to 0.92). It correlated strongly with decision satisfaction ($r = -0.40$ to -0.60), decisional conflict ($r = 0.31$ to 0.52), and overall rated quality of life ($r = -0.25$ to -0.27). Groups differing on feelings

about a decision also differed on rated regret: $F(2, 190) = 31.1, P < 0.001$.
Regret was greater among those who changed their decisions than those who did not, $t(175) = 16.11, P < 0.001$. CONCLUSIONS: The scale is a useful indicator of health care decision regret at a given point in time.

Publication Types:

Validation Studies

PMID: 12926578 [PubMed - indexed for MEDLINE]

Med Decis Making. 2003 Jul-Aug;23(4):275-80.

A new model of medical decisions: exploring the limits of shared decision making.

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This article proposes a model of medical decisions based on 2 fundamental characteristics of each decision--importance and certainty. Importance reflects a combination of objective and subjective factors; certainty is present if 1 intervention is superior and absent if 2 or more interventions are approximately equal. The proposed model uses these characteristics to predict who will have decisional priority for any given decision and shows how one class of decisions lends itself particularly well to shared decision making. Three other types of decisions are less well suited to a collaborative decision: 1) For major choices that have low certainty, patients should be encouraged to be the primary decision makers, with physician assistance as needed. 2) Most minor decisions that have high certainty are expected to be made by physicians. 3) Major decisions that have high certainty are likely to cause serious conflict when patients and physicians disagree.

PMID: 12926577 [PubMed - indexed for MEDLINE]

Med Econ. 2003 Aug 22;80(16):76.

When a patient refuses transfer.

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PMID: 12964547 [PubMed - indexed for MEDLINE]

Med Econ. 2003 Jul 25;80(14):88.

Patient vs family: we have to play a role.

Kushner DA.

PMID: 12931513 [PubMed - indexed for MEDLINE]

Med Educ. 2003 Sep;37(9):840-1.

Sexual feelings in the physician-patient relationship: recommendations for teachers.

Spiegel W, Colella T, Lupton P.

Publication Types:

Letter

PMID: 12950951 [PubMed - indexed for MEDLINE]

Med J Aust. 2003 Sep 1;179(5):263-6.

Chronic illness and sexuality.

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Sex remains an important contributor to quality of life in many patients with chronic illness and their partners. The effects of chronic illness on sexuality are multifactorial and can impact on all phases of sexual response. Sexual dysfunction and dissatisfaction in chronically ill patients are underdetected and undertreated because of barriers to doctor-patient discussion about sex and lack of medical training in human sexuality. For doctors to become more motivated to broach the topic of sex, they need to recognise that people may be sexually interested even though they are old, ill or disabled. The PLISSIT model provides a graded counselling approach that allows doctors to deal with sexual issues at their own level of expertise and comfort.

PMID: 12924976 [PubMed - indexed for MEDLINE]

Med J Aust. 2003 Sep 1;179(5):253-6.

Getting it right: why bother with patient-centred care?

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Patient-centred care is about sharing the management of an illness between patient and doctor; it is not new but is increasingly evidence-based, especially for chronic problems such as diabetes, asthma and arthritis. Systematic reviews show that patient-centred care results in increased adherence to management protocols, reduced morbidity and improved quality of life for patients. Key features of the doctor-patient interaction are shared goal setting, written management plans and regular follow-up. Supportive community-based services and programs, combined with healthcare system commitment, are also required to make this approach effective in improving population health.

PMID: 12924973 [PubMed - indexed for MEDLINE]

MGMA Connex. 2003 Aug;3(7):36-41, 1.

Improving customer service. It's not just what's in the box.

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Patient satisfaction scores can plummet when medical emergencies throw schedules into disarray or a receptionist ignores a patient at the front desk. Patients' expectations of good customer service have been shaped by technological conveniences and the concerted efforts of retailers, restaurants and other service providers. Physician leaders and administrators can improve customer service by paying more attention to organizational culture, physician behavior, staff incentives, hiring practices and team-building.

PMID: 12959055 [PubMed - indexed for MEDLINE]

MGMA Connex. 2003 Aug;3(7):42-5, 1.

Say cheese. Photo mapping lets you see your practice as patients do.

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Photo mapping--creating a photographic map of all parts' of the practice that your patients see--helps physicians and staff view their practice through the patients' eyes--literally the patient focus. Once this happens, a group can more easily make changes that can improve patient satisfaction.

PMID: 12959056 [PubMed - indexed for MEDLINE]

Qual Lett Healthc Lead. 2003 Aug;15(8):2-11, 1.

Improving customer satisfaction and quality: hospitals recognized by J.D. power and associates share insights on meeting patient and employee needs.

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For 35 years, J.D. Power and Associates has presented its much-coveted awards recognizing product and service quality and customer satisfaction in a variety of industries. This year, the company added a new category: hospitals. To better understand patients' reactions to their hospital experiences, the company looked at five key drivers of customer satisfaction: dignity and respect, speed and efficiency, comfort, information and communication, and emotional support. This issue looks at five hospitals recognized by the company for their service excellence and why they emphasize employee satisfaction as well as patient satisfaction.

PMID: 12961834 [PubMed - indexed for MEDLINE]

Qual Manag Health Care. 2002 Summer;10(4):29-37.

Enhancing VHA's mission to improve veteran health: synopsis of VHA's Malcolm Baldrige award application.

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The Veterans Health Administration (VHA) provides health care value to an aging veteran population in the midst of rising health care costs and the necessity to demonstrate improvements in the quality of care. The Malcolm Baldrige framework offers a comprehensive assessment of the organization's management system, performance improvements, and the promise to enhance health outcomes, including quality and patient satisfaction. This article will describe the development, current status, and future plans within VHA for the Malcolm Baldrige Award for Healthcare.

PMID: 12938254 [PubMed - indexed for MEDLINE]

Rehabil Couns Bull. 1999 Winter;43(1):41-50.

Ethical dilemmas related to counseling clients living with HIV/AIDS.

Garcia JG, Froehlich RJ, Cartwright B, Letiecq D, Forrester LE, Mueller RO.

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This study tested an eight-factor model of client actions/decisions in terms of the extent to which professionals counseling persons with HIV/AIDS believed that those actions/decisions presented ethical dilemmas, and the frequency with which they encountered such actions. A confirmatory factor analysis lent initial support for the hypothetical eight-factor ethical-dilemma model for the ratings regarding the extent to which the participants believed those items constituted ethical dilemmas. Similar results were obtained for the frequency ratings, but in this case a second, competing model was equally plausible. Several significant predictors of participant ratings were found and are discussed.

PMID: 13678077 [PubMed - indexed for MEDLINE]

Soc Sci Med. 2003 Oct;57(8):1409-19.

It is hard work behaving as a credible patient: encounters between women with

chronic pain and their doctors.

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In various studies during the last decade, women with medically unexplained disorders have reported negative experiences during medical encounters. Accounts of being met with scepticism and lack of comprehension, feeling rejected, ignored, and being belittled, blamed for their condition and assigned psychological explanation models are common. Women patients exerted themselves to attract the doctor's medical attention and interest, and were anxious to be considered as whiners or complainers. Here, we explore the nature of "work" done by the patients in order to be believed, understood, and taken seriously when consulting the doctor. A qualitative study was conducted with in-depth interviews including a purposeful sampling of 10 women of varying ages and backgrounds with chronic muscular pain. The main outcome measures were descriptions reflecting the patients' activities or efforts invested in being perceived as a credible patient. We focused on the gendered dimensions of the experiences. The women patients' accounts indicated hard work to make the symptoms socially visible, real, and physical when consulting a doctor. Their efforts reflect a subtle balance not to appear too strong or too weak, too healthy or too sick, or too smart or too disarranged. Attempting to fit in with normative, biomedical expectations of correctness, they tested strategies such as appropriate assertiveness, surrendering, and appearance. The most important activities or efforts varied. However, the informants were not only struggling for their credibility. Their stories illustrated a struggle for the maintenance of self-esteem or dignity as patients and as women. The material was interpreted within a feminist frame of reference, emphasising the relationship between dignity and shame, power and disempowerment for women patients' with medically unexplained disorders.

PMID: 12927471 [PubMed - indexed for MEDLINE]

Soc Sci Med. 2003 Oct;57(8):1375-85.

Disarmed complaints: unpacking satisfaction with end-of-life care.

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Difficult health care encounters often do not translate into expressions of dissatisfaction with care. This paper focuses on the 'non-expression' of dissatisfaction with care in the accounts of 12 people in Canada who provided care to a relative or friend who died of breast cancer. The analysis foregrounded in this paper began from the observation that as difficult health care experiences were elaborated, speakers located health professionals' actions in relation to various situational factors, including the fact of a (cancer) death and conditions of constraint in the health system. Set alongside these two realities, expressions of dissatisfaction tended to be disarmed. Results of this study suggest that the cost of articulating dissatisfaction with care is high where the cared-for person has died, and the perceived value of focusing on difficult experiences is low. Further, respondents in this study took the specificity of the situation and the setting into account in formulating beliefs about the care outcomes for which health professionals could be held responsible. When conditions in the health system and the disease process of advanced cancer were positioned in talk as 'ultimate limits' on health professionals' actions, perceived lapses in care were excused.

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