Quality of Care

Larson EB. Evidence-based medicine: is translating evidence into practice a solution to the cost-quality challenges facing medicine? *Jt Comm J Qual Improv* 1999 Sep;25(9):480-5.

Abstract: BACKGROUND: Evidence-based medicine (EBM) and practice guidelines have been embraced by increasing numbers of scholars, administrators, and medical journalists as an intellectually attractive solution to the dilemma of improving health care quality while reducing costs. However, certain factors have thus far limited the role that EBM might play in resolving cost-quality trade-offs. FACTORS FOR SUCCESS OF EBM RECOMMENDATIONS AND GUIDELINES: Beyond the quality of the guideline and the evidence base itself, critical factors for success include local clinician involvement, a unified or closed medical staff, protocols that minimize use of clinical judgment and that call for involvement of so-called physician extenders (such as nurse practitioners and physician assistants), and financial incentive. TROUBLESOME ISSUES RELATED TO COST-QUALITY TRADE-OFFS: Rationing presents many dilemmas, but for physicians one critical problem is determining what is the physician's responsibility. Is the physician to be the patient's advocate, or should the physician be the advocate of all patients (the patients' advocate)? How do we get physicians out of potentially conflicted roles? EBM guidelines are needed to help minimize the number of instances physicians are asked to ration care at the bedside. If the public can decide to share and limit resources — presumably based on shared priorities — physicians would have a basis to act as advocates for all patients. CONCLUSIONS: Although EBM alone is not a simple solution to the problems of increasing costs and public expectations, it can be an important source of input and information in relating the value of service and medical technology to public priorities.

✓Daffurn K. Roles of acute care nurse practitioners, physician assistants, and resident physicians in acute care settings [editorial]. *Am J Crit Care* 1998 Jul;7(4):253-4.

In an introduction to the Rudy et al. article, which follows, the author stresses the team effort required for critical care and notes the blurring of traditional physician relationships with new team members in critical care.

✓Rudy EB; Davidson LJ; Daly B; Clochesy JM; Sereika S; Baldisseri M; Hravnak M; Ross T; Ryan C. Care activities and outcomes of patients cared for by acute care nurse practitioners, physician assistants, and resident physicians: a comparison. *Am J Crit Care*; 1998 Jul;7(4): 267-81.

BACKGROUND: Little information is available on the practice of acute care nurse practitioners and physician assistants in acute care settings. OBJECTIVES: To compare the care activities performed by acute care nurse practitioners and physician assistants and the outcomes of their patients with the care activities and patients' outcomes of resident physicians. METHODS: Sixteen acute care nurse practitioners and physician assistants and a matched group of resident physicians were studied during a 14-month period. Data on the subjects' daily activities and on patients' outcomes were collected four times. RESULTS: Compared with the acute care nurse practitioners and physician assistants, residents cared for patients who were older and sicker, cared for more patients, worked more hours, took a more active role in patient rounds, and spent more time in lectures and conferences. The nurse practitioners and physician assistants were more likely than the residents to discuss patients with bedside nurses and to interact with patients' families. They also spent more time in research and administrative activities. Few of the acute care nurse practitioners and physician assistants performed invasive procedures on a regular basis. Outcomes were assessed for 187 patients treated by the acute care nurse practitioners and physician assistants and for 202 patients treated by the resident physicians. Outcomes did not differ markedly for patients treated by either group. The acute care nurse practitioners and physician assistants were more likely than the residents to include patients' social history in the admission notes. CONCLUSIONS: The tasks and activities performed by acute care nurse practitioners and physician assistants are similar to those performed by resident physicians. However, residents treat patients who are sicker and older than those treated by acute care nurse practitioners and physician assistants. Patients' outcomes are similar for both groups of subjects.

✓Sekhon LJ. Medical practice evaluation: adding a physician assistant. *Del Med J* 1998 May;70(5):253-5. COMMENTS: Comment in: *Del Med J* 1998 May;70(5):257-8.

Rocca PV. Yet another suggestion to improve quality of care [editorial; comment]. *Del Med J* 1998 May;70(5):257-8. COMMENTS: Comment on: *Del Med J* 1998 May;70(5):253-5.

Davidson J. Issues in quality care. Take a positive approach to peer review. *J Am Acad Phys Assist* 1998 Mar;11(3):14, 17.

Falligant L. Physician assistants (PAs) provide quality care [published erratum appears in *Wis Med J* 1997 Aug;96(8):8] *Wis Med J* 1997 Jun;96(6):13-4.

DeFacio L. Quality management: new toolbox for better medicine. *J Am Acad Phys Assist* 1997 Feb;10(2);27,30,33.

Quality management is a means of identifying deficiencies; of acknowledging superior performance; of recognizing educational needs; and of analyzing and explaining differences in practice patterns and outcomes of care.

Burke WE. Tools for evaluating performance quality. *J Am Acad Phys Assist* 1996 Sep;9(9);21-22,27-28.

Discussion of performance profiling — the purpose of tracking, the methods of gathering data and analysis of the data. The overriding goal is to improve practice by understanding how a provider performs with a given group of patients.

Mattingly DE; Curtis LG. Physician assistant impairment. A peer review program for North Carolina. *N C Med J* 1996 Jul-Aug;57(4):233-5.

Mott JS; Borden SL. The impaired PA. *J Am Acad Phys Assist* 1994 Oct;7(9):682-4.

Since the 1986 American Academy of Physician Assistants House of Delegates established the first task force to address impairment issues directly, the AAPA has developed continuing education sessions, publications, and workshops on impairment topics. Most constituent chapters now have impairment contacts and have developed, or are in the process of developing, mechanisms regarding impairment. The 1992 Constituent Chapter Officers Workshop included a special presentation on developing impairment mechanisms. In 1993, the AAPA established a formal relationship with the Federation of State Physician Health Programs, the national organization of physician impairment and diversion programs.

Kober CE. Physician assistant impairment issues. A primer on an important professional/peer review issue. *Phys Assist* 1993 May;17(5):73-6, 78-9.

Abstract: Like other health professionals, PAs must deal with the issue of impairment. An impaired practitioner is one who is unable to practice medicine with reasonable skill and safety because of physical or mental illness, including age-related impairment, loss of motor skills, and substance abuse. Because PAs practice under the supervision of licensed M.D.s, they face unique problems when their supervisor is impaired. The AAPA's Code of Ethics and Strategic Plan both stress the responsibilities of individual PAs and PA organizations to address impairment issues. The suggested model for self-regulation is the disciplinary/grievance model, which allows the profession to meet its ethical and legal responsibilities regarding quality, competent health care while providing a compassionate, caring program for impaired PAs/supervisors. ■