It is my hope that, as the American people see more evidence that they are paying for redundant and useless medical procedures, they will demand in larger numbers that real reforms be enacted to address this problem. That is what makes studies like the one by Bishop et al so important.

Sen Orrin G. Hatch

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The Price of Excess: Identifying Waste in Healthcare Spending

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RESEARCH LETTERS

Increasing a Patient’s Ability to Identify His or Her Attending Physician Using a Patient Room Display

One aspect of improving patient safety and satisfaction in the hospital is the patient’s ability to communicate with his or her principal caregiver. The first step in this communication chain is identification of the primary attending physician. Unfortunately, in many teaching institutions this can be difficult for a patient. Patient care at many teaching institutions includes multiple health care providers, such as the primary attending physician, resident physicians, consulting physicians, and fellows. With such a multitude of house staff interacting with the patient on a daily basis, it is common for patients to experience confusion when trying to identify their primary attending physician. Physicians contribute to this problem by not introducing themselves properly.1 Nonteaching hospitals can have similar difficulties owing to the rise of the use of hospitalists who assume inpatient care from the patients' regular primary care physicians.2

A recent article in the Archives reported that only 281 of 2807 patients (10%) were able to correctly identify any inpatient physician in charge of their care.3 To see if we could improve this problem, we conducted a study to see if constant visual representation of the physician’s name increases the patient’s ability to correctly identify his or her primary attending physician.

Methods. We prospectively studied 150 patients hospitalized within the Internal Medicine Teaching Service; 50 patients were placed in rooms without a dry erase board and 100 with a dry erase board on which the attending physician’s name was to be displayed daily. Patients were assigned to rooms by the normal central administration routine, without knowledge of which rooms were equipped with the boards. Patients in both groups were informed of their attending physician’s name and met all of the physicians on their care team within the first 24 hours of hospitalization. Patients in the rooms with dry erase boards were informed once on admission by the nurse that their attending physician’s name, nurse’s name, and hospital service were displayed on these boards in their rooms. Patients with moderate to severe dementia or any uncorrected visual problems were excluded from the study.

Twenty-four hours after admission to the floor, the patients in each study group were asked the identical question: “Using any means at your disposal, can you name your attending physician?” In addition to patient responses, the accuracy and completeness of the dry erase board information was recorded. Of the 100 patients with a dry erase board in their room, the name of the attending physician was not displayed on the board for 4 patients, and these 4 patients were excluded from the study. Thus, a total 146 patients were studied, of whom 50 had no dry erase board in the room and 96 had a dry erase board in their room on which the attending physician’s name was displayed.

The proportion of patients who were correctly able to identify the name of their coordinating attention physician was recorded separately in patients with and without visual representation of the attending physician’s name on a dry erase board in the room. Exact binomial 95% confidence intervals (CIs) were calculated for these proportions. The difference between these 2 proportions was also estimated, along with the 95% CI, and the 2 proportions were compared using the Fisher exact test, for which \( P < .05 \) was considered statistically significant. Statistical analyses were performed using S-Plus software (version 8.0.1; Insightful Corporation, Seattle, Washington).

Results. Age, ethnicity, length of hospital stay, presence of corrected cataracts, and presence of mild dementia or memory loss was similar between the 2 groups of patients, with and without visual representation of the attending physician’s name on a dry erase board in their room (Table). However, the proportion of men was noticeably higher in patients with visual representation of the attending physician’s name (60% vs 36%).

Table. Characteristics of 2 Groups of Patients, With and Without Visual Representation of the Attending Physician’s Name

<table>
<thead>
<tr>
<th>Variable</th>
<th>No Visual Representation of Physician Name (n=50)</th>
<th>Visual Representation of Physician Name (n=96)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>73 (27-100)</td>
<td>67 (18-97)</td>
</tr>
<tr>
<td>Sex, male, No. (%)</td>
<td>18 (36)</td>
<td>58 (60)</td>
</tr>
<tr>
<td>Ethnicity, white, No. (%)</td>
<td>46 (92)</td>
<td>86 (90)</td>
</tr>
<tr>
<td>Corrected cataracts, No. (%)</td>
<td>3 (6)</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Mild dementia or memory loss, No. (%)</td>
<td>5 (10)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Length of hospital stay, d</td>
<td>5 (1-20)</td>
<td>4 (1-52)</td>
</tr>
</tbody>
</table>

*The sample median (minimum-maximum) is given for age and length of hospital stay.*

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Of the 50 patients without visual representation of their attending physician’s name on a dry erase board, only 5 (10%; 95% CI, 3%-22%) were able to correctly identify the name of their attending physician. There was very strong evidence that this proportion was higher for patients with visual representation of their attending physician’s name (P < .001), of whom 94 of 96 patients (98%; 95% CI, 93%-100%) were able to correctly identify their attending physician’s name. This indicates that compared with patients with no visual representation, the proportion of patients who were correctly able to identify the name of their attending physician was 88% higher (95% CI, 76%-94%) for patients with visual representation of their attending physician’s name in their room. Of note, of the 4 excluded patients for whom the attending physician’s name was not written on the dry erase board, none were able to correctly identify the name of that physician.

Comment. Our results confirm that patient knowledge of their attending physician is poor, since only 10% of our control group was able to identify the name of their attending physician correctly. This is consistent with previous findings. With a simple modification of having the name reliably visualized in front of them, we improved this knowledge in virtually all patients interviewed (98%). Although this may have been expected, as the name was written for patient reference, previous studies have found that repeated visualization of medical information improved recall significantly even after the information was no longer visualized. One limitation of our study is that although the patients showed improved name recognition, we are unsure if this process would improve face recognition. Francis et al found that the use of photographs helped patients identify hospital team members, and this led to higher overall patient satisfaction. A similar study using physician photographs posted on a patient room display would be an interesting next step.

On the basis of our findings, we conclude that a simple system that includes visual representation of all of the health care team’s names and responsibilities can help improve the awareness of patients’ identification of their medical providers.

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Author Contributions: Study concept and design: Maniaci. Acquisition of data: Maniaci. Analysis and interpretation of data: Maniaci, Heckman, and Dawson. Drafting of the manuscript: Maniaci, Heckman, and Dawson. Critical revision of the manuscript for important intellectual content: Maniaci and Dawson. Statistical analysis: Heckman. Administrative, technical, and material support: Maniaci. Study supervision: Dawson.

Financial Disclosure: None reported.


Reasons for Discontinuation of Medication During Hospitalization and Documentation Thereof: A Descriptive Study of 400 Geriatric and Internal Medicine Patients

Medication is often changed or discontinued during hospital admission, and this is especially true for medications prescribed to elderly patients. However, after discharge further changes to medication regimens are not always intentional and may be due to poor communication. For example, in an earlier study, we found that adverse drug reactions detected during hospitalization and requiring cessation of the causative drug were poorly communicated to primary care professionals (general practitioners and pharmacists), leading to a rate of represcription of withdrawn medication of 27% during the first 6 months after discharge. The study highlighted the need for better communication of reasons for discontinuation of medication. Adequate documentation of these reasons can only exist on the condition that these reasons are well documented. Our experience in daily practice is that such documentation is often inadequate. The objectives of the present study were to evaluate the frequency of reasons for discontinuation of medication and the documentation thereof in hospitalized patients.

Methods. We studied the medical records (paper and/or electronic) of consecutive patients admitted to the geriatric and internal medicine wards of the University Medical Center Utrecht (n = 200) and the Catharina Hospital in Eindhoven (n = 200), the Netherlands, to determine which medications were used before hospitalization. Discontinuation was defined as stopping or switching to another drug within the same therapeutic range. Prescribed and discontinued medications and dates of discontinuation were extracted from electronic prescription programs, and then patient records were reviewed to determine whether the reasons for discontinuation of these medications at these dates had been recorded. Reasons for discontinuation were categorized as “adverse drug reaction,” “contraindication,” “no longer indicated,” “interaction,” “palliation,” “ineffective,” “no reason mentioned,” “at request of patient,” or “other.” Discontinuation of antibiotics after completion of a course and of potassium supplementation after nor-