TRENDS & Ideas

PHYSICIANS

The Dilemma of Domestic Violence

Although primary care physicians are in a good position to identify victims of domestic violence and refer them for intervention, most physicians hesitate to become involved in the problem, Nancy Kathleen Sugg and Thomas Inui report in *JAMA*.

Sugg interviewed 38 primary care physicians from a large urban health maintenance organization, asking them to describe cases of domestic violence they had managed, to explain the role they took in such cases, and to report their own experiences of violence or abuse. The study's goal was "to uncover the barriers to domestic violence intervention from within the physician's frame of reference."

Sim Gellman

One powerful obstacle to intervention was physicians' fear and uncertainty about the effects of raising the issue. Physicians who came from white, middle-class families were especially hesitant to bring up the subject with persons from a similar background—in part, some confessed, because doing so would expose them "to their own fear of vulnerability and lack of control."

Physicians also feared that probing the possibility of domestic violence would offend patients. A number of male physicians thought that broaching the subject would strike many patients as "a betrayal of trust" that could potentially undermine the physician-patient relationship. Interestingly, none of the women physicians interviewed expressed this fear.

Another difficulty for some physicians was their belief that to diagnose domestic violence was, in effect, "to 'accuse' the partner of being a batterer." Physicians also felt they did not have the tools or the power to address such a complex problem. Finally, a majority of those interviewed said they simply did not have enough time to ask about the possibility of violence in the home.

Sugg and Inui suggest that education may help physicians cope with the dilemmas that arise when they confront evidence of domestic violence. Only three of the doctors Sugg interviewed said they had been well trained in this area, whereas 23 revealed they had had no education at all on the issue. And any attempt to teach doctors how to approach domestic violence, the authors conclude, "must include examining and reshaping internal barriers that may hinder physicians' clinical skills."

COMMUNITY BENEFIT

Cancer Educational Programs and Screenings

More than 42,000 persons who died from cancer in 1991 could have been saved through education and early detection and treatment, according to the American Cancer Society. In an effort to help area residents become aware of warning signs and seek early treatment for various types of cancer, Bentonville, AR–based Bates Memorial Hospital launched the Save a Life program in January 1991.

Throughout the year Save a Life offers an integrated series of educational programs and screenings. Each month the program covers a different type of cancer, such as colon, rectal, skin, breast, or prostate cancer, or related topics such as hospice and smoking cessation.

In many hospitals, such programs are spearheaded by a single employee. Because Bates has such a small staff, however, the administrative director of imaging services led a steering committee of managers and employees who established the program's vision and operational plan. The hospital's consulting oncologist provided assistance through the program's development and continues to do so now that it is in place.

The educational programs, which are usually held at the hospital, are free. Because physicians and other professionals donate their time, most screenings are also free. Patients are charged only when a mammography screening is covered by insurance. The Phillips Pro-Celebrity Charity Classic, an annual golf, tennis, and fishing tournament, supports the Bates program through a grant.

Key to the program's success is the hospital medical staff's voluntary participation in conducting screenings. If a certain specialty is not represented on the medical staff, volunteers from other facilities participate.

Although Bates Memorial Hospital is a small facility, its Save a Life program has accomplished much. By June 1992, 1,026 people had attended the educational sessions, and 1,951 persons had been screened for various types of cancers. Screenings detected 208 abnormal findings. Of these, 75 were confirmed as cancer. When cancer is suspected, those persons are referred to the appropriate physician.

Bates President Thomas P. O'Neal attributes the accomplishments of the Save a Life program to the community's encouragement and the large number of area residents who have attended educational sessions and screenings. He also credits the steering committee's commitment to the program. "The people involved feel they really make a difference in saving lives," says O'Neal.

INFORMATION TECHNOLOGY

Keeping the Hospital Team Connected

Within a few years pen-based computers will be an indispensable tool in many hospitals, keeping physicians and nurses in constant contact with one another and with the information they need to do their jobs, predicts Mark Wheeler, senior vice president of new technology development at Pharmis, Inc., Seattle.

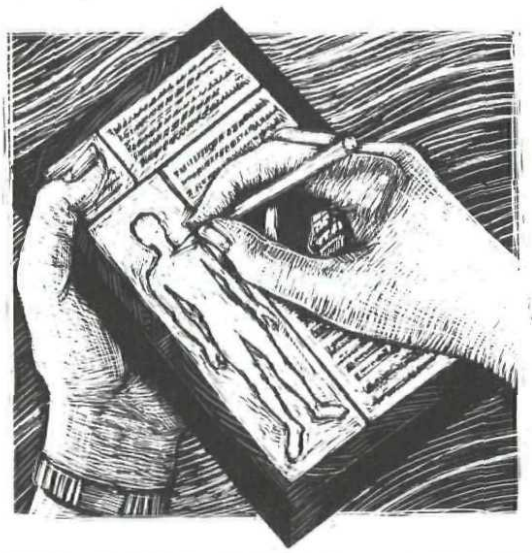
Speaking at a session at the Computers in Healthcare Conference in San Diego in May, Wheeler said the devices will weigh about 12 ounces and be the size of a paperback book. When properly integrated with the hospital information system, they will give users instant access to any information in the system data base relevant to their jobs. But perhaps their most important feature will be the ability to receive and transmit voice messages.

The new technology, Wheeler said, will enable hospital personnel to do their jobs more efficiently and to provide better-quality care. Physicians and nurses using the devices will be able to alert co-workers immediately in emergencies. And the computers will be programed to give alerts when monitors signal that a patient is in distress and needs quick attention.

Wheeler noted that the pen will be a pointing, rather than a writing, instrument. For example, by first touching the appropriate function in a list on one part of the screen and then touching the throat area in an outline of the human body on another part, a physician could call up a list of possible diagnoses of a tracheal ailment. Having arrived at a diagnosis, the physician could then find out the recommended treatment, the Medicare diagnosis-related group, or a list of specialists to whom the patient might be referred. The physician could then dictate changes to the patient's chart and send the update to a central location, where it would be transcribed.

Wheeler warned, however, that the new technology will not be without its problems. The computers will be easily stolen or lost, and some nurses and physicians will not want to carry them. But "the hard problem," he said, is that the device "is going to change the behavior of so many people."

Managing this transformation, Wheeler concluded, will be a challenge. "We have to find out what it will take to allow people to assimilate change like this. Pen-based computers will have a greater impact on the hospital environment than any information technology we have introduced in the past."



HEALTH INSURANCE

Collaboration May Prevent Fraud

With 4 billion health insurance claims processed annually, it is easy to see why fraud and abuse can go undetected for years. Collaboration among insurers may be the key to ridding the healthcare system of such defects, says the U.S. General Accounting Office (GAO) in its May 1992 report, "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse."

In 1991, 10 percent ($70 billion) of total healthcare spending was lost to fraud and abuse, estimates the GAO. "This diverts scarce resources and contributes unnecessarily" to healthcare costs, which made up 12 percent of the 1991 gross national product, the federal agency notes.

Examples of fraudulent or abusive practices include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

Health insurance fraud and abuse appears to be rampant, but the many activities that occur when claims are processed make it difficult for insurers to detect wrongdoing, says the GAO.

For example, a single claim, filed in isolation, rarely alerts insurers to fraud. With physicians, for example, "insurers need to view claims within the context of the physician's entire practice or in relationship to other physicians' billing practices," explains the GAO. "Working collaboratively could give insurers opportunities to confirm or deny suspicion about a provider and to document the information necessary to develop viable fraud cases."

However, insurers' concerns about privacy limit their ability to collaborate. Also, "there is a lack of consensus concerning the appropriate regulation of new provider types and financial arrangements," notes the GAO. And, it adds, the legal and administrative costs of pursuing fraud may outweigh the benefits.

The agency proposes that Congress establish a national commission to counter health insurance fraud and abuse. The commission would include public and private payers and federal and state investigative and prosecutorial agencies "to develop strategies and evaluate legislative remedies for combatting health insurance fraud and abuse." Specifically, the commission would gather information and make recommendations on issues such as standardizing claims administration, allowing insurers more freedom to exchange information, and extending administrative remedies available to public insurers.