Questioning the Inspectors

In the early twentieth century hospitals were unregulated and care was arbitrary, nonscientific and often poor. The Flexner report of 1910 and the establishment of hospital standards by the American College of Surgeons in 1918 began the process of hospital inspection and improvement (1). The later program eventually evolved into what we know today as the Joint Commission. Veterans Administration (VA) hospitals have been inspected and accredited by the Joint Commission since the Reagan administration.

The VA hospitals often share reports regarding recent Joint Commission inspections and disseminate the reports as a "briefing". One of these briefings from a recent Amarillo VA inspection was widely distributed as an email attachment and forwarded to me (for a copy of the briefing click here). There were several items in the briefing that are noteworthy. One was on the first page (highlighted in the attachment) where the briefing stated, "Surveyor recommended teaching people how to smoke with oxygen, not just discuss smoking cessation". However, patients requiring oxygen should not smoke with oxygen flowing (2,3). It is not that oxygen is explosive but a patient lighting a cigarette in a high oxygen environment can ignite their oxygen tubing resulting in a facial burn (2,3). A very rare but more serious situation can occur when a home fire results from ignition of clothing, bedding, etc. (3).

A quick Google search revealed no data for any program teaching patients to smoke on oxygen. It is possible that the author of the "briefing" misunderstood the Joint Commission surveyor. However, the lack of physician, nurse and respiratory therapist autonomy makes it easy to envision administrative demands for a program to "teach people how to smoke on oxygen" wasting clinician and technician time to do something that is potentially harmful.

Although this is an extreme and absurd example of healthcare directed by bureaucrats, review of the remainder of the "briefing" is only slightly less disappointing. Most of the Joint Commission's recommendations for Amarillo would not be expected to improve healthcare and even fewer have an evidence basis. The Joint Commission focus should be on those standards demonstrated to improve patient outcomes rather than a series of arbitrary meaningless metrics. For example, a Joint Commission inspection should include an assessment of the adequacy of nurse staffing, are the major medical specialties and subspecialties readily accessible, is sufficient equipment and space provided to care for the patients, etc. (4-5). By ignoring the important and focusing on the insignificant, the Joint Commission is pushing hospitals towards arbitrary and nonscientific care reminiscent of the last century. These poor hospital inspections will undoubtedly eventually lead to poorer patient outcomes.

Richard A. Robbins, MD*
Editor

References

1. Borus ME, Buntz CG, Tash WR. Evaluating the Impact of Health Programs: A Primer. 1982. Cambridge, MA: MIT Press.
2. Robb BW, Hungness ES, Hershko DD, Warden GD, Kagan RJ. Home oxygen therapy: adjunct or risk factor? J Burn Care Rehabil. 2003;24(6):403-6. [CrossRef] [PubMed]
3. Ahrens M. Fires And Burns Involving Home Medical Oxygen. National Fire Protection. Association. Available at: http://www.nfpa.org/safety-information/for-consumers/causes/medical-oxygen (accessed 3/12/14).
4. Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA. 2002 Oct 23-30;288(16):1987-93. [CrossRef] [PubMed]
5. Harrold LR, Field TS, Gurwitz JH. Knowledge, patterns of care, and outcomes of care for generalists and specialists. J Gen Intern Med. 1999;14(8):499-511. [CrossRef] [PubMed]

*The views expressed are those of the author and do not necessarily reflect the views of the Arizona, New Mexico, Colorado or California Thoracic Societies or the Mayo Clinic.