

Almost Getting With the Guidelines: Fame or Shame?

To the Editor:

I am uncomfortable with Vaishnava and Eagle's¹ satisfaction to observe the clear improvement over time with more than 90% adherence for each performance measure (aspirin within 24 hours, discharge with aspirin and beta-blockers, patients with low ejection fraction discharged with angiotensin-converting enzyme inhibitors/angiotensin receptor blockers, smoking-cessation counseling, use of lipid-lowering medication) for patients discharged after acute myocardial infarction.²

First, this has been too slow, and tens of thousands of patients were denied adequate treatment for too long. Claiming that "deviations (from the standard of care) are considered medical errors" may explain why. Chronic lack of implementation of basic care is more than error, it is a faulty and damaging behavior of the profession.

Second, smoking-cessation counseling is a totally inadequate indicator. These patients deserve intensive interventions, not counseling.³ Moreover, the term "performance indicator" is confusing; this is only process, and we need

outcome. The Joint Commission raised the bar with a new tobacco-cessation measure set, effective on January 1, 2012.⁴

Vaishnava and Eagle¹ should have looked forward: What is the percentage of patients taking beta-blockers 6 months after discharge or benefiting from cardiac rehabilitation program? Quality of care needs humility and ambition, not satisfaction.

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References

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