

I've been thinking...



Some Overlooked Benefits of BPOC

June 2008

I've been thinking about physicians, bar coding, and WIIFM?

Recently, while pondering why the physician community has been seemingly immune to the bar-coding-at-the-point-of-care (BPOC) bug, I had an idea. Maybe it's because they've been dialed in to WIIFM—not an FM radio station for Nintendo's Wii but the abbreviation text-messaging types use to ask "What's in it for me?"

My idea arrived while rereading Dr. Robert Wachter's 2 May 08 blog entitled, [Should Hospitals Install Bar Coding or CPOE First? Why I've Changed My Tune](#). While asking himself the question why CPOE had gained so much more momentum than bar coding over the past decade, the pioneer of hospitalist medicine suggested a theory:

"In the early days of clinical IT, many of the movers and shakers were physician-informaticists, and they had to sell the case for change (and considerable investment) to their fellow physicians if there was to be any hope of their hospital taking the IT leap. It is logical that they would have deemed prescribing errors to be the main culprit; those are the ones that they themselves had committed and witnessed." He added, "Despite their importance, administration errors (which represented more than one-third of all medication errors) were ignored by physicians."

Is this just another way of saying few physicians seem to have found WIIFM in BPOC? Contrary to the stereotype, not all physicians are only concerned about the M. Most would add a P to our abbreviation. They want answers to What's in it for my patients? This is illustrated in the rest of Wachter's May 2 musings.

It appears that during his brief participation as the keynote speaker for [The unSUMMIT for Bedside Barcoding](#), Wachter caught the BPOC bug. On his flight from Austin back to San Francisco, he wrote:

I started thinking about the big, high-profile errors I've heard about in the last year or two, both at UCSF and nationally. And I had an epiphany. Or maybe it was the turbulence. But here goes.

At UCSF Medical Center . . . virtually every terrible medication error case I can recall in the past couple of years involved a nurse administering a medicine.

Thinking about this drumbeat of tragedies, I tried to recall a major medication error in the last few years that would have been prevented by CPOE (computerized physician order entry) . . . and I couldn't. Not that there aren't any, but it does seem like today's Oh-My-God-How-Could-This-Happen med errors are now disproportionately administration, not prescribing, mistakes.

Moreover, with everybody now on their toes about medication safety, an errant prescription has many downstream opportunities (pharmacist, nurse, even patient or family) to be caught before it kills.

On the other hand, there is generally nothing that stands between the busy nurse who makes a dose calculation error or confuses a vial of heparin for insulin—and tragedy. The nurse has only one chance to get it right, and no safety net if she gets it wrong.

Even though the (BPOC) evidence continues to trail (CPOE), based on what I know today, if I was a hospital ready to get into the IT game, I'd go with bar coding first.

Anything but self-centered, the good doctor is thinking about the best interests of his patients and their nurses.

A week later, I received the following e-mail:

TO: Mark Neuenschwander

FROM: Robert Wachter

SUBJECT: Today's JAMA

MESSAGE: Important article in support of bar coding, FYI — [Barcoded Medication Administration—A Last Line of Defense](#)¹

I promptly read the article, and hope you will too, in which Toronto physicians David Cescon and Edward Etchells conclude a compelling case for BPOC with a plea: "Nurses have long served as the last line of defense against medication errors. The health care system must wait no longer to provide them, and all patients, with the systematic safety net that they deserve."

While I applaud these doctors on both sides of the border for seeing what's in BPOC for others, I also appeal to them to take another look at What's in it for them? The most overlooked value of BPOC, in my opinion, is its contribution for supplying physicians with more accurate medication-administration records (MAR). When assessing patients' needs, do not doctors utilize MARs to determine whether to continue, discontinue, or amend drug therapies? Too often medications are charted long after they have been administered, interruptions have occurred, and memories have lapsed. Some administrations are charted in error. Others are not charted at all. What physician wants to write orders based on inaccurate MARs?

While none of the above MDs overtly indicated the value of BPOC to physicians, the Canadians did note that "BCMA automatically generates an accurate electronic medication administration record, improving both patient care and hospital invoicing." I would add that it improves physicians' practice of medicine.

And, while I'm with the docs in seeing the WIIFM of CPOE, I'd like to suggest that no CPOE software is capable of healing inaccurate MARs. There is more WIIFM in BPOC than has met the average physician's eyes.

¹ JAMA. 2008;299(18):2200-2202 (doi:10.1001/jama.299.18.2200) P 2201

BPOC's got SIIFE—something in it for everyone.

What do you think?

A handwritten signature in black ink, appearing to read 'Mark Neuenschwander', written in a cursive style.

Mark Neuenschwander

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