Quality Improvement Not Embedded in Physicians' Professional Culture

Audet AM, Doty MM, Shamasdin J, Schoenbaum SC. Measure, learn, and improve: physicians' involvement in quality improvement. Health Aff (Millwood) 2005;24:843–53.

Study Overview

Objective. To assess U.S. physicians' access to their own quality of care data and views on sharing quality of care data.

Design. Cross-sectional survey.

Setting and participants. A random sample of U.S. physicians directly involved in adult patient care and who were part of the American Medical Association Physician Masterfile were mailed a survey in 2003. Specialists who were unlikely to be involved in a patient's case long term (eg, radiologists, pathologists) were excluded.

Main outcome measures. Answers to questions about access to practice-level data, access to and sources of quality of care data, involvement in redesign (quality improvement) efforts, and attitude toward sharing quality of care data. Predictor variables included years in practice, practice size, salaried versus nonsalaried, hours per week of patient care, and use of electronic medical records.

Main results. 1837 surveys were completed (response rate, 52.8%). Only 49% of physicians reported that it would be very or somewhat easy to generate a list of patients by age-group, and only 44% could do so by diagnosis. Few physicians reported that it would be very or somewhat easy for them to generate a list of patients according to abnormal laboratory values (16%) or prescribed medications (15%). Only 20% of physicians received any data about how many of their patients received a care process (eg, a screening test), and only 18% received any data about patients' clinical outcomes (eg, glycemic control in patients with diabetes). 34% were involved in redesigning a delivery system to improve quality of care. 71% of physicians thought that medical leadership should have access to quality data, 44% thought that their own patients should not have access to performance data, and 31% thought this data should not be available to the general public. In multivariate analyses, solo practitioners and physicians in small groups were less likely to have access to practice data or internally generated quality of care data or to be involved in redesign efforts compared with physicians working in larger groups. Specialists were less likely than primary care physicians to have access to quality of care data or to be involved in redesign efforts. Regular use of an electronic medical record was strongly associated with access to data in univariate analyses but in multivariate analyses was only significantly associated with access to internally generated quality of care data.

Conclusion. Most physicians do not routinely have access to data summarizing their performance, and most do not participate in redesigning the delivery system to improve the quality of care. Physicians in midsize and large practices are much more likely than solo practitioners to have access to their own practice-level performance data. Physicians are reluctant to share data about their performance with their patients or the public. Physicians have not fully embraced quality improvement principles and methods.

Commentary

Achieving the highest quality medical care has been an elusive goal. Decades of research have documented gaps in health care quality, and considerable efforts have been expended to develop and implement a means for quality measurement in a variety of settings. Tools are now available that can facilitate quality measurement and quality improvement activities (eg, computerized information systems). Despite these trends, most U.S. physicians have not incorporated quality improvement tools and methods into routine practice, and quality improvement has not been inculcated into the professional culture.

The findings of Audet and colleagues are not surprising. Obstacles to the growth of a quality improvement culture are formidable. Most physicians are rewarded based on the quantity of the patients they see and not the quality of the care they provide. Resources expended on infrastructure and staff to advance quality improvement reduce the resources available to support increased productivity. Even in marketplaces where physicians are rewarded for high-quality care ("pay for performance"), it may not be financially worthwhile for physicians to invest large resources in

system redesign to improve the quality of care they deliver if only a small amount of their total revenue is at stake [1]. Small physician groups and solo practitioners may be at a greater disadvantage when it comes to instituting quality improvement because they lack the economy of scale available to larger groups.

In a system where quantity is rewarded over quality, it is understandable that most physicians object to sharing their quality data with the public. However, physicians may not be able to successfully resist the trend toward more public disclosure of physician performance data.

This study's findings may have overestimated the true extent to which physicians are engaged in quality improvement. Physicians were asked about whether they had access to "any" data. Many physicians who gave affirmative responses may only have data from small subsets of patients, such as those participating in particular health plans. In addition, physicians who responded to the survey may have done so because they hold more favorable views toward quality improvement compared with nonresponders.

Applications for Clinical Practice

Stakeholders such as purchasers, accrediting bodies, health plans, and consumers may care more about measuring the quality of health care provided by individual physicians than they do physicians themselves. Quality improvement is not an integral part of the contemporary medical culture. Because active quality measurement and improvement is not widespread, physicians who engage in these activities may be able to distinguish themselves from peers who do not. The long-term financial consequences for practicing physicians who make these cultural changes are unknown.

–Review by Stephen D. Persell, MD, MPH

Reference

1. Epstein AM, Lee TH, Hamel MB. Paying physicians for high-quality care. N Engl J Med 2004;350:406–10.