

# Physicians, professionalism and organizational efforts to improve quality – A systems perspective

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The article by Bartell and Smith, in this issue of the *Wisconsin Medical Journal* (p. 66), which looks at the relationship between physicians' professionalism and quality improvement as it has evolved to date, is an excellent summary addressing the issues as seen from a physician's perspective up to this point. In addition, the article provides a good summary of the systems approach for a potential solution to providing optimal health care, which fits well with the physician's role.

It is imperative that we change the way we provide health care in this country. One only needs to look at the Institute of Medicine report, *Crossing the Quality Chasm*, the Leapfrog initiative by the leading Fortune 500 companies, and the National Quality Foundation to realize the national priority for health care changes. All are working to put out evidence-based standards for care for defined patient populations to ensure the best health care value. The efforts we see across the country are in conjunction with the health care crisis we are experiencing and are projecting to experience in the future, regarding the uninsured, underinsured, limited access, disparity in care, increasing cost of care, and patient safety.

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**Table 1.** Components Needed to Ensure the Ultimate Health Care Value

$\text{Health Care Value} = \text{Appropriateness} \times \text{Clinical Quality} \times \text{Service Quality} \times \text{Patient Safety}$
$\text{Cost}$

The driving force in health care is to get the optimal value. The equation in Table 1 illustrates the components needed to ensure the ultimate health care value.

Providing the best health care value, in my opinion, will result in the best overall patient care.

Physicians' professionalism, which comes from the Hippocratic Oath and the altruistic values of the physicians, really obligates physicians to become leaders in providing the best health care value. The Hippocratic Oath teaches physicians to treat the sick to the best of their ability, preserve patient privacy, pass professional knowledge on to others in the profession, and to be patient advocates. Providing the best health care value serves these principles.

One of the great challenges we have today is to maintain and optimize the treatment of each individual patient, while recognizing that we need to be able to identify different patient populations and document optimal care for them. Our history of health care has been illness-based, individual-based, and often reactive-based care. This care was delivered on the belief that we, as physicians, were delivering opti-

mal care to the whole population. However, there is documented evidence showing that in the majority of cases in populations such as diabetics, hypertensives, and immunized children—when identified and studied without a systems approach to delivering the optimal care—individual physicians failed to provide state-of-the-art care to the majority of these patient populations. Speaking from personal experience, I have found this to be true in my practice.

Another great challenge we face today is that the majority of us have worked in physician groups under the definition: "a physician group is an entity created for physicians to come together to be alone." My 30 years of experience as a rural family physician and as a medical director of a provider-owned health plan have provided me with the perspective that this is true in many cases. For example, if we had eight physicians, we would have eight different processes for scheduling appointments, dealing with strep throat, and what lab work was important enough to be done.

Attempts at trying to provide standardization without a systems approach has failed many times in

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the past. A systems approach certainly has had the most success in providing a documented high level of care for the patients we see.

Physician leadership in collaborative quality efforts is imperative and an obligation of our professionalism. The key is leadership, not control or power. Physicians who provide leadership and their knowledge and skills in a collaborative way will be in the position they desire to provide the care they were trained for. To be successful, health care leaders, including physicians, need to become actively involved in the change and ensure the appropriate resources are available to allow this change to happen.

Physicians must also acknowledge and help to change the documented lack of standard clinical processes and designated personnel to provide the care needed for our different patient populations.

Not having standardized clinical processes and designated personnel to manage our different populations is a major barrier to providing the best health care value. Physician reimbursement has been built around piece work, often procedure-based, illness models for care. These incentives are often in conflict with what is required to provide overall optimal care to our patients. A clinical quality bonus to recognize and reward the attain-

ment of the defined clinical outcome and process measures can be a very needed force to improve care. The bonuses can defray the expenses of designing, implementing, and improving standardized clinical processes, which can include adding needed staff.

Physician leadership on clinical and administrative teams providing the optimal care will overcome the thoughts of many that clinical quality improvement often gets done despite physicians, and processes are designed around physicians, not with physicians.

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