Physicians need help crossing the “quality creek”

I read with interest the editorial on quality, “Crossing the quality creek” (Frey J. Crossing the quality creek. WMJ. 2006;105:20). I think the shift of the metaphor from the “chasm” to “creek” is appropriate and useful. Successfully engaging physicians in quality improvement is perhaps the greatest difficulty faced in the quality field today. For many doctors, the water metaphor shifts to: “It’s hard to think about draining the swamp when you are waist deep in alligators.” The stresses of daily practice leave little time and energy for looking at improvement efforts. The proliferation of guidelines that seem more like mandates and looming pay-for-performance measures make it more frightening than exciting.

Educating physicians about guidelines and “academic detailing” has yielded few positive results. The electronic medical record may help in collecting data, but few provide clinical decision support of an adequate interactivity to guide care. To gain acceptance with physicians, quality improvement efforts must not only improve patient care, but enhance our efficiency. We must develop tools such as preprinted orders, standing orders, checklists, and other methods of integrating best practices into daily patient care. Our local quality leaders and our professional societies must show us “where the rocks are” in crossing the quality creek.

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Freedom to choose

The recent Wisconsin Medical Journal was dedicated to explaining and detailing the multitude of organizations, associations, projects and collaborations that have been organized to direct patient care. Milton Friedman, in his introduction to F.A. Hayek’s classic, The Road to Serfdom, stated: “The coordination of men’s activity through central direction or voluntary cooperation are roads going in very different directions: The first to serfdom and the second to freedom.”

Unfortunately, it is the former road to serfdom that I believe medicine is traveling.

It will not be a voluntary coordination but rather coercion through pay for performance and ultimately into the depths of universal healthcare/single payer system that medicine will fall.

I take no comfort in the fact that “the profession” (with the noblest of intentions) is developing the guidelines, because in the end they will be used to coerce us into uniformity and conformity. I fully support striving to improve quality and develop the best medical practices we can, but in the end the patient must be the one to decide quality, not the third party payer. If we continue to allow government and insurers to increasingly direct patient care it will be an enormous blow to freedom. The freedom to practice what kind of medicine, how, when, and to whom. The freedom of patients to choose what is the best care for them as an individual/family and to choose who will deliver it. The freedom of medicine to dare to try “variations of treatment” to innovate and solve problems. The freedom to “cross the creek” at the best spot for the patient, even though that big, beautiful bridge built by the government and insurers may seem the easier way to go. For on the other side of that bridge will be conformity and mediocrity for all, not better quality for all.

The road to better quality and more affordable health care in Wisconsin is the road with more choices, more competition, and less government intrusion.

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The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article, contact the *Wisconsin Medical Journal* at 866.442.3800 or e-mail wmj@wismed.org.

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