A Physician’s Perspective on Quality & Patient Safety

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Overview

• Traditional healthcare delivery model
• Call for a new model
• Understanding the physician perspective
• Strategies for engagement
• Benefits of physician involvement
The Traditional Model

- Healthcare professionals responsible for safe and quality care
- Focus on the needs of individual patients
- Doctors practice autonomously; not hospital employees
- Hospital provides infrastructure, support and resources to deliver patient care

- Undergo extensive training and evaluation
- Evaluate new knowledge and adjust practice accordingly
- Bound by oath, ethics – commitment to the patient good
The Traditional Model

• Focus on the needs of individual patients
  – Unit of care is the provider-patient encounter
  – Trained using case-based examples
  – Provider-patient relationship paramount

The Traditional Model

• Doctors practice autonomously; not system/ hospital employees
  – Historical relationship
    • hospitals restructured to a bureaucratic model
    • physicians responsible to patients; to a third-party would constitute conflict of interest
    • Thus relationship with institution – through the Medical Staff Organization
  – Felt to protect patient advocation
  – Practice in multiple locations
The Traditional Model

• Hospital provides infrastructure, support and resources to deliver patient care
  – With formation of MSO – Doctors responsible for patient activity, safety, performance – oversight by MSO
  – Administration provided oversight of the plant, employees, finances, resources

Sounds like a good model built on good intentions
Does the model work?

What happens when you measure?

Chart 2-1
Estimated Deaths Associated with Medical Mistakes Compared to the Leading Causes of Death in the U.S.

<table>
<thead>
<tr>
<th>Cause</th>
<th>Deaths in 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart diseases</td>
<td>726,974</td>
</tr>
<tr>
<td>Cancers</td>
<td>539,577</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>159,701</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>109,029</td>
</tr>
<tr>
<td>Medical mistakes (IOM high estimate)</td>
<td>98,000</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>95,644</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>86,449</td>
</tr>
<tr>
<td>Diabetes</td>
<td>62,636</td>
</tr>
<tr>
<td>Medical mistakes (IOM low estimate)</td>
<td>44,000</td>
</tr>
<tr>
<td>Suicide</td>
<td>30,535</td>
</tr>
<tr>
<td>Nephritis and related</td>
<td>25,331</td>
</tr>
</tbody>
</table>

Sources: IOM 2000, Kassanow et al. 1999 (deaths).
Why?

• Medical science and technology have advanced at an unprecedented rate

• Healthcare has become very complex

• The healthcare system assumes that well intentioned healthcare professionals will provide quality and safe care through hard work, vigilance and use of evidence
A call for a new model

- “a higher level of quality cannot be achieved by further stressing current systems of care”

- “the courage, hard work, and commitment of the healthcare workforce are, today, the only real means we have of stemming the flood of errors

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A call for a new model

- The healthcare system needs to see the implementation of evidence-based, safe and quality medicine as an system responsibility, rather than the sole responsibility of individual clinicians

- Physicians are essential partners in system redesign – if true improvement is to be realized
The Pressure to Change is On

- Growing attention to quality/safety issues
- Era of accountability
  - To accreditors – safety/quality ROPs
  - To government – public reporting
  - To public – access, wait-times
  - To patients – disclosure, apology
- Everyone must/is getting in the new game

“How do we get the physicians to be more interested/in involved in our safety and quality improvement plans/initiatives?”
A Physician’s Perspective

• Safety and quality is at the core of physician practice
  – “Primum non nocere”
  – Striving to do their best for every individual patient they see
  – Hold accountability for life and death
  – Deeply rooted in medical education – perfection is the necessary goal

A Physician’s Perspective

• Different view of safety and quality
  – Individual outcomes over population
  – Clinical outcomes over administrative
  – Tension between patient-centred care and whole-system improvement

“I’m less concerned about the care of your last 9 patients; I am concerned about how well you will care for me and my kids”
A Physician’s Perspective

• Fiercely autonomous
  – Embedded in training, CME/CPD
  – Duty to advocate for patients despite resources, financial pressures, politics
  – “Legal captain of the ship”
  – We’ve been given it = the traditional model

“If I’m personally responsible then I must have complete control and autonomy in the decisions about care”

A Physician’s Perspective

• Physician as personal identity
  – What we do is what we are
  – Mistakes are seen as personal failures
  – Fear of being shunned by community; need for belonging
A Physician’s Perspective

• Evidence and data driven
  – Trained to seek and use data
  – Show me the numbers; raw
  – Pressure to change practice – evidence from rigorously conducted research
  – BUT…discuss/ debate knowledge collaboratively; implement it individually
  – AND…essentially no training in QI methodology/ science

A Physician’s Perspective

• Time is limited and precious
  – Time devoted to patient care = better time spent
  – Administrative activities of less value
  – High demand for clinical time – no time for less valued activities
  – Frustrated by system inefficiencies
Becoming More Involved

• Understanding the physician perspective
  – Enables physicians to seek/create opportunities to become more involved
  – Enables staff/administrators to design initiatives using strategies to attract/engage physicians

• Understanding that physician culture is a barrier
  – Need to be more open to change

Engaging Physicians in a Shared Quality Agenda

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- John W. Whittington, MD: Patient Safety Officer and Medical Director of Knowledge Management, OSF Healthcare System; IHI Senior Faculty
Engagement Strategies

- **Discover common purpose**
  improve patient outcomes, reduce hassle and wasted time

- **Create partnerships**
  Physician not contractor; hospital not supplier/controller
  Share responsibility with individual and system of patients

- **Involve physicians early**

- **Work with medical leadership**
  Division director, Chair MAC, Physician in chief

- **Identify/ be a champion**
  find/ be a vocal believer, consider making/ being project lead
Engagement Strategies

- Standardize/protocolize evidence
  Start with aspects that are agreed upon with evidence

- Use (local) data to drive change
  Use aggregate data to show change is needed
  Use meaningful/agreed upon quality indicators

- Make the right thing easy to try
  Involve MDs in PDSA/reliability tests

- Make the right thing easy to do
  Avoid plans that add more work for MDs or others

- Make physician involvement visible

Does higher physician involvement improve quality?
### Table 1. Attributes of successful improvement

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>* Organizations value, support, and acknowledge all members to participate. * Organizations foster open communication and transparency.</td>
</tr>
<tr>
<td>Leadership</td>
<td>* Strong, visionary leadership creates an environment for organizational culture. * Leadership utilizes and empowers employees to improve. * Strategic and operational leadership collaborate to create a vision and share goals. * Leadership is committed to organizational improvement and continuous improvement.</td>
</tr>
<tr>
<td>Strategy and Policy</td>
<td>* Strategic plans and policies are integrated into clinical strategies and aligned with organizational goals.</td>
</tr>
<tr>
<td>Structure</td>
<td>* Values and priorities are aligned with organizational goals.</td>
</tr>
<tr>
<td>Resources</td>
<td>* Supplies and equipment are accessible and efficient.</td>
</tr>
<tr>
<td>Information</td>
<td>* Information is available and accessible.</td>
</tr>
<tr>
<td>Communication</td>
<td>* Communication is effective and supports improvement initiatives.</td>
</tr>
<tr>
<td>Physician Involvement</td>
<td>* Physicians are involved in planning improvement initiatives and participate as team members. * Opportunities for physician and clinical leadership of improvement. * Clinicians &quot;own&quot; improvement.</td>
</tr>
</tbody>
</table>
High performing organizations

- Quality by Design
  - Henry Ford, Jonkoping, Intermountain Health, National Health Service, Veterans Health, Calgary Health Region, Trillium Health Centre
- Baldridge Award Winners
- Pursuing Perfection Hospitals, IHI

Can physicians benefit from being involved in quality improvement?
Physician Benefits - Examples

- Professional Development/ Career Opportunities
  - Demand for physician leaders in QI/patient safety
- Improvement in group practice
  - OR booking efficiency, orthopedics
- Improvement in own practice
  - Quality review of ENT procedures
  - Checklist reminders in office practice

Summary

- The traditional medical model is failing to deliver the care that we and the public expect
- A new model is emerging which requires partnership, flexibility and change between all parties – including physicians
Summary

- Physician professional culture important factor in level of involvement in quality improvement activities
- Opportunities to develop strategies for physicians to seek involvement and hospitals to gain engagement
- Higher quality is obtainable while maintaining our individual commitment to patient care

Thank you

- Questions??
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