Myth Busters

March 2007

A SERIES OF ESSAYS GIVING THE RESEARCH EVIDENCE BEHIND CANADIAN HEALTHCARE DEBATES

MYTH We can improve quality one doctor at a time

THE SOLO DOCTOR WHO EMBODIES EVERY PROCESS NEEDED TO ENSURE HIGHEST-QUALITY CARE IS NOW NEARLY A MYTH. ALL PHYSICIANS DEPEND ON SYSTEMS, FROM THE LOCAL ONES IN THEIR PRIVATE OFFICES TO THE GARGANTUAN ONES OF NATIONAL HEALTH CARE.[i]

QUALITY PROBLEMS ARE PERVASIVE. BUT POOR QUALITY IS NOT A RESULT OF A SERIES OF INDIVIDUAL MISTAKES.[ii]

Individual doctors are often singled out as "bad apples" when healthcare safety is lacking.[iii] In the same way, when it comes to achieving a high-quality healthcare system, doctors are frequently regarded as the system's lone rangers, standing to improve quality of care one "first-rate" doctor at a time.[i] But the performance of the healthcare system depends on the actions of many players: just imagine a row boat with a team of rowers pulling on the oars; one is a doctor and is rowing at a completely different rhythm from the rest of the team. Progress will be slow, frustrating for all, and with a great deal of splashing and bruising.

The belief that quality of healthcare rests solely on the shoulders of doctors has led to strategies focused on improving the quality of care offered by individual physicians through approaches such as clinical practice guidelines. Clinical guidelines have long been regarded as key to improving quality of care; this idea is based on the notion that if we gather the evidence on appropriate healthcare for specific circumstances and tailor this evidence to the needs of individual practitioners, we can improve professional practice and health outcomes.[iv] Unquestionably, guideline development is worthwhile, but doctors face a number of barriers — including those that are beyond their control — that serve to undermine guideline implementation.[v-vii] For example, physician adherence to clinical guidelines often relies on systems-level improvements such as acquisition of new resources, facilities, and enhanced staff support.[v, viii, ix] One academic put it best when he said "There has been a preponderance of patient-level outcome studies within a biomedical paradigm which is incomplete without attention to the context within which patients receive their care."[x]

There's undeniably no "magic bullet" when it comes to improving clinical practice,[xi] and the same is true for improving quality in healthcare.[xii, xiii] A more promising strategy would bear in mind not only the evidence on effective practice, but the evidence on how to transform the healthcare system at large.

No Simple Prescription

While the popular focus is on solo doctors, we know "no person acting alone is as effective as a team to drive best practices and outcomes."[xiv] And looking beyond the clinical level, a broader team exists. It is at the macro level, where managers and policy makers drive system-wide quality improvement initiatives, including greater use of information technology, performance measurement and reporting, and integration of services.

Few would dispute the significance of interprofessional collaboration in promoting safe, efficient, and quality healthcare.[xv, xvi] Teams are less prone to making mistakes than individuals, especially when team members are well-aware of their and their team members' roles and responsibilities.[xvii, xviii] And a healthcare system that supports effective teamwork can improve the quality of care through enhanced patient safety and reduction of workload issues

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causing burnout among healthcare professionals.[xix] Systematic reviews of collaboration and teamwork also show effectiveness across a range of chronic conditions — from cancer to mental health to geriatric care — ultimately leading to shorter hospital stays, reduced costs, and increased patient satisfaction.[xx-xxiii] An additional benefit of teamwork is its ability to help with effective transfer of evidence to practice.[viii]

Taking a Systems Approach

Another important contribution from research is to consider processes (such as information and patient flow)[xxiv] and systems (suites of processes) for improving healthcare outcomes.[xxv]

The "theory of continuous quality improvement" (or CQI) counteracts the still-popular "theory of bad apples"[i, iii] and operates on the principle that, while healthcare providers aim to do their best, they are limited by faulty healthcare processes.[i, xxv, xxvi] With an emphasis on improving processes and systems for improving healthcare quality, CQI initiatives take the heat off individuals.

One example of CQI functioning at its best comes from the American Department of Veterans Affairs (VA), which initiated a "system-wide re-engineering" to improve its quality of care in the mid-1990s.[xxvii] Taking a systematic approach to measure, manage, and be held accountable for quality, the VA saw a drastic upgrade in its overall performance, with statistically significant improvements for all quality indicators collected from 1994-95 through to 2000.[xxvii] In addition to instituting routine quality indicators and performance measurements and introducing an electronic medical record system, the VA's success relied on performance contracts and making performance data public, which served to make managers accountable for meeting quality improvement goals.[xxvii]

Conclusion

Physicians aim to provide quality healthcare for their patients, but they cannot achieve high-quality healthcare alone or without support. If we are to improve healthcare quality, we must focus our attention at the systems level — the "big picture" — and involve multiple actors, from healthcare providers to managers and policy makers.

Mythbusters are prepared by knowledge transfer and exchange staff at the Canadian Health Services Research Foundation and published only after review by experts on the topic.

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