In current Canadian physician culture, the belief in individual physician responsibility for patient welfare and outcomes is powerfully ingrained. Ultimate success in diagnosis and treatment results from years of personal hard work, study, diligence, dedicated commitment, and assumption of personal responsibility. We are intensely attached to individual autonomy—if I am personally responsible, I must have complete control and autonomy in decisions about care. The legal system and regulatory authorities for years have reinforced this concept of individual physician responsibility in assessing patient outcomes. The buck stops here. Accountability has been clear. It could be argued that this value served us relatively well in the 20th century, and to an extent, it still does.

But this fierce devotion to personal autonomy has serious drawbacks. When things go wrong, we tend to “shame and blame” other care providers for not meeting standards of care. This often leads to cover-ups, self-protection, accumulation of errors, and poorer patient outcomes. The inability to share decision making about patient care can also lead to dysfunctional team interaction and consequent poorer outcomes. The system perspective is lacking.

This value of personal individual responsibility is in direct conflict with the central tenet of quality improvement (QI)—that most quality outcomes are system attributes, rather than individual provider attributes. A systems view of quality of care leads away from a blaming culture. It facilitates improved communication and function among health care professionals. It fosters a culture of innovation, change, and support, and a sharing of autonomy in designing common systems of care that all providers can use to improve patient outcomes and safety. High-quality patient care is better care—patient-centred, equitable, timely and accessible, safer, more effective, efficient, integrated, continuous, and sustainable. Better and high-quality care saves time and money—for us and for society.

Given this need for a systems perspective on care, it is critical to promote both individual and system responsibility for quality. As individual family doctors we must remain responsible to do our personal best and be accountable to our patients and society. Our prime motivator is our patients’ health and we, like most humans, want to become better at doing things that matter. Our knowledge, abilities, and skills can always be improved.

Thus we must not only remain involved in personal continuing professional development, but also extend ourselves to improving the health care systems and processes we work with every day: from our own office procedures to improved care delivery in our hospitals, communities, and regions. To do this requires education, supports, and tools. The trend to QI is worldwide. The US Institute for Healthcare Improvement is a prime resource for information, programs, and training in QI (www.ihi.org). Australia, New Zealand, the Netherlands, and the United Kingdom are also at the forefront of developing primary care QI initiatives. Since about 2000, Canada too has been a leader in QI for our health system in general and for family medicine in particular. This is enabling us to begin transforming how we practise to achieve better health care results.

Health quality councils are emerging across Canada. Legislation, such as Ontario’s Excellent Care for All Act, provides the legal and systemic framework for QI. The Quality Improvement and Innovation Partnership (www.qip.ca) has been developed to carry out the primary care QI agenda and is a superb resource for family physicians carrying out their own QI initiatives. The Quality in Family Practice Resource Database is a regularly updated online resource for The Quality Book of Tools, a comprehensive book of practice management and clinical care indicators for improving quality in primary care and family practice. Departments of family medicine across Canada are developing QI programs and training to assist family physicians, teams, and residents with QI and to encourage research to ground changes in best evidence (eg, the University of Toronto). In the Patient’s Medical Home—CFPC’s vision for primary care in Canada—the quality indicators for family medicine (from access and equity to electronic health records and team-based care) are built into the foundation of the model, and regular re-evaluation and QI are integral.

Donald Berwick, CEO of the Institute for Healthcare Improvement, writes, “You win the Tour de France not by planning for years for the perfect first bicycle ride but by constantly making small improvements.” Begin small and be specific, but begin. Start to measure what you do, because unless you measure, you cannot improve. Avail yourself of the existing QI resources and support. And welcome to family medicine in the 21st century.

References


