

Competing interests

None declared

References

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Quality, accountability, and transparency

We have met the enemy and he is us.
Pogo

In his editorial in the August 2012 issue,¹ Dr Nicholas Pimlott encourages medical organizations like the College of Family Physicians of Canada to become leaders in promoting good stewardship of our health care resources and better outcomes for patients. He then asks rhetorically, “What would that look like?”

In the same issue, Shortt and Sketris² argue that optimal prescribing is needed especially when expenditures for drugs approximate 16% of total health costs. Rather than just asking what that would look like, they go on to outline several interventions. Of those suggestions only audit and feedback will satisfy the need for quality, accountability, and transparency.

Federal and provincial governments, health boards, and administrators are increasingly asking whether they are getting the most bang for their (limited) health care bucks. The focus is on physicians, both as a cost to the system and as the generators of cost. Cost and sustainability go hand in hand and too often trump quality, which should be the mantra of physicians.

Governments have brought in a variety of measures to ensure cost-effectiveness under the guise of quality. Not having anything to show on quality, we have been distracted by these same measures. Take, for example, fee-for-performance. In at least one Canadian province, physicians are given a year-end bonus if they see patients with diabetes quarterly and send them for blood and urine tests consistent with clinical practice guidelines. Is this a good use of resources? I argue it is not.

Two years ago I audited all of my patients with diabetes for their hemoglobin A_{1c} values. (With an electronic medical record this took only 30 minutes. The same work done 8 years previously took 3 working days for data abstraction.) Hemoglobin A_{1c} is a surrogate outcome measure, although a valuable one. There were 2 clusters of values; one around

6.8%, the other around 7.8%. My focus, while continuing to monitor those with the better—that is, lower—values (albeit less often than guidelines recommend) is to concentrate more resources on those who stand to have improved hemoglobin A_{1c} levels. Under fee-for-performance I would not be compensated for this approach.

One might say that fee-for-performance has shown itself to be a valuable tool. There is little evidence this is true. In fact, changes in physician behaviour came about because their work was being examined—the Hawthorne effect. Audit and feedback can achieve change in physician behaviour. It is a requirement of having the privilege of being a self-regulating profession. We really do not know what we are achieving unless we measure our work.

The August issue provides a further article that can be used for an audit in oral anticoagulation in atrial fibrillation.³ In the spring of 2012, I audited all patients in my practice with atrial fibrillation and assigned each a CHADS₂ score and a HAS-BLED score, asked whether they were taking warfarin or acetylsalicylic acid, and the reasons why or why not. I then summarized the results and posted a single-page summary in the waiting room for patients to read.

In the fall of 2011 I conducted a Beers criteria audit. Beers criteria comprise a list of drugs that are potentially troublesome in the elderly because of substantial, serious, or even fatal side effects. One hundred consecutive charts of patients older than 65 years of age were reviewed with the Beers criteria. Sixty-eight percent of those reviewed were taking none of the drugs listed as needing to be avoided. This compared favorably with a benchmark of 71% obtained in a specialized geriatric assessment unit. Those results were also posted in my waiting room.

There are many opportunities for small-scale but meaningful audit in each doctor’s practice. Our focus can remain on quality and not costs. To our shame, our licensing boards, medical societies, and associations have dragged their collective feet and not taken any concrete action to see that self-audit of every physician’s practice is achieved. We need to begin now.

We should be proud to stand up, show our results, and say, “This is our work.”

—Paul Bonisteel MD CCFP FCFP
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Competing interests

None declared

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Correction

Une erreur s’est glissée dans la traduction du résumé de l’article intitulé « Les Canadiens acceptent-ils