

*Quality of Health Care***PART 6: THE ROLE OF PHYSICIANS  
IN THE FUTURE OF QUALITY  
MANAGEMENT**

PREVIOUS articles in this series discussed alternative ways to define the quality of health care,<sup>1</sup> state-of-the-art methods for measuring and improving quality,<sup>2,3</sup> the origins of the quality debate,<sup>4</sup> and the implications of capitated payment arrangements for the quality of care.<sup>5</sup> Many readers may remain unsure, however, about how efforts to measure and manage quality in our health care system will evolve, and about how physicians should respond. In this concluding article in the series, we review some likely near-term developments in society's continuing efforts to improve the quality of care, and we discuss their implications for physicians and their patients.

**MEASUREMENT AND REPORTING  
OF QUALITY**

The most visible and, for some physicians, the most disquieting result of the recent interest in measuring the quality of care is the emergence of reporting systems rating health care providers. Ten years ago, public reporting of data on the quality of health care was a distant rumor. Now, quality report cards seem ubiquitous.

Many report cards rely on quality measures from the Health Plan Employer Data and Information Set (HEDIS)<sup>6,7</sup> or data from patient-satisfaction surveys. By one account, health plans and employer groups have issued nearly 50 different report cards in the past two years alone, based on surveys, other indicators, or both.<sup>8</sup> Mass-market magazines such as *Newsweek* and *Consumer Reports* have joined the health-plan survey business as well. With support from several major industrial organizations, Dr. Paul Ellwood recently created the Foundation for Accountability (FACCT) with the purpose of developing disease-specific quality-reporting mechanisms.<sup>9</sup>

Government is also entering the report-card business. Having abandoned its unsuccessful Medicare hospital-mortality reporting system,<sup>10</sup> the Health Care Financing Administration is working with the National Committee for Quality Assurance (NCQA), the developer of HEDIS, to fashion report cards tailored to the special needs of the Medicare and Medicaid programs. State governments in New York and Pennsylvania (soon to be joined by California) are issuing reports on hospitals and physicians performing coronary-artery bypass grafting and will probably expand the list of conditions for which data are re-

leased. Pennsylvania has been reporting outcomes of acute myocardial infarction for some time.

Reporting of quality measures is likely to prove an enduring feature of our new health care system. Such reports respond to the deeply felt need of many influential groups, including public and private purchasers and managed-care health plans, for better data to inform their choices among health care plans or to manage their internal operations. Nevertheless, the number and variety of different quality-reporting systems is a source of increasing confusion and irritation to many providers of health care services, and agreement on a national standard for quality report cards seems both desirable and likely.

The HEDIS data set is closer than any other reporting system to achieving this status,<sup>11</sup> but, at least in its current form, HEDIS is unlikely to satisfy the needs of all the parties with an interest in quality measurement. HEDIS responds most clearly to the desire of large, organized purchasers for data on the performance of health care plans — organizations with responsibility for many thousands of enrollees. Physicians, however, are likely to find the current HEDIS data set incomplete. Of the 60 measures contained in HEDIS, 40 concern utilization and management. Only nine focus on the quality of care received by individual patients, and these consist primarily of health plans' records on the provision of routine preventive services.<sup>12</sup> Physicians are likely to find report cards more meaningful if they include indexes that better represent the broad spectrum of medical services they provide to individual patients with acute and chronic illnesses.

Therefore, although report cards on the performance of health plans may become standardized, we are also likely in the short term to see the expansion of existing instruments, especially HEDIS. NCQA has established a process to update HEDIS so as to incorporate a broader set of quality measures as these are developed.<sup>13</sup> Because of the unique role of physicians in the health care system, these new reporting instruments are likely to include expanded measures of the clinical performance of individual physicians. Some may also include assessments of health plans based on physicians' perceptions of the quality and efficiency of the plans in question.

Report cards that focus on practitioners' performance are likely to be especially controversial. There is currently considerable disagreement about what report cards measuring the quality of physicians' performance should emphasize and whether available measures are likely to prove valid, reliable, and useful. If pressed to define measures of the quality of care provided by physicians, physicians themselves generally favor indicators of technical quality, including detailed, disease-specific measures of the processes of care.<sup>3</sup> For example, was the patient with

an acute myocardial infarction given the correct diagnosis and treated appropriately with thrombolytic therapy in a timely manner? Did the patient with severe chronic asthma receive inhaled steroids or cromolyn? At the same time, physicians are extremely concerned about potential flaws in such data, such as the failure to adjust appropriately for case mix and severity of illness.

In contrast, consumers seem to support strongly the release of data on the performance of individual practitioners. Patients tend to believe that their doctors, more than their health plans, determine the quality of care they receive. Consumers also seem unlikely to sympathize with physicians' trepidations concerning the potential deficiencies in report-card data. At the same time, they may find it difficult to appreciate technical measures of quality and may place greater weight than physicians on measures of convenience for patients, such as physicians' availability and waiting times for appointments.

Thus, it seems fair to say that in the area of quality measurement and reporting, physicians can expect little relief from the feeling that they increasingly work in a fishbowl and are being judged by groups and measures with which they have little familiarity. Managing this reality is one of the greatest challenges confronting the profession at the current time.

#### QUALITY IMPROVEMENT

The rationale for the measurement and reporting of quality rests largely on the belief that the public release of data on performance will lead to behavioral change and improved quality. Such data are intended to guide patients' choices, purchasers' contracting decisions, and physicians' referrals. These, in turn, along with the professional ethos, are expected to motivate institutional and individual efforts to improve performance by means of such new techniques as guidelines, appropriateness standards, and industrial methods of quality management.<sup>3</sup>

The experiences of New York and Pennsylvania with the public reporting of statewide outcomes data provide natural experiments with these ideas. Since 1989 and 1991, respectively, these states have compiled annual statistics on risk-adjusted mortality after coronary-artery bypass surgery for individual hospitals and surgeons.

Studies of the Pennsylvania and New York experiences provide a mixed picture. There is evidence that the release of data motivated hospitals in New York to improve the quality of care. Between 1989 and 1992, during the first four years of the reporting system, there was a 41 percent decline in risk-adjusted mortality associated with coronary-artery bypass grafting.<sup>3</sup> Some hospitals restricted the privileges of surgeons with low volumes of procedures who had relatively high risk-adjusted mortality rates; other hospitals embarked on efforts to identify and im-

prove specific processes that might be responsible for higher-than-expected mortality.

Studies of responses by patients and physicians highlight another side of the story. Despite the availability of data demonstrating clear differences among surgeons in risk-adjusted mortality, there is no statistical evidence that patients in New York have migrated to surgeons with better ratings. For their part, physicians clearly took note of the data. Green and Wintfeld<sup>14</sup> found a dramatic increase in recorded coexisting conditions among patients undergoing bypass surgery in New York State, which they attributed to changes in coding practices by physicians and hospitals wishing to improve their risk-adjusted statistics.

Public reporting may also have affected patients' access to services. In a survey of cardiovascular surgeons in Pennsylvania, a majority said they were less willing, since the state's reporting system began, to operate on severely ill patients who needed bypass surgery<sup>15</sup>; none said they were more willing than before reporting began.

Whether public reporting in Pennsylvania and New York has actually compromised patients' access to care remains uncertain at this point. It is notable that California has adopted a plan to release data on mortality related to coronary-artery bypass surgery for hospitals, but that it will not provide surgeon-specific data (Brook R: personal communication).

The ability of providers to respond constructively to the public release of data depends, of course, on a variety of considerations. One is the availability of methods for changing the processes of care to achieve better outcomes. In this endeavor, a potential tool is "total quality management" and its repertoire of quality-improvement tools.<sup>16,17</sup>

Total quality management has a long history of improving quality in industries other than health care. However, despite its clear successes in particular instances,<sup>18,19</sup> there is so far no convincing scientific evidence that the application of the techniques of total quality management in health care improves the quality of care in entire institutions or among large numbers of physicians. Part of the reason may be the short time that the health care industry has been applying these techniques — barely a decade. Another explanation may lie in the labor-intensive and detailed work that is required to redesign systems of care that vary from institution to institution and from condition to condition. The information necessary to improve the outcomes of bypass procedures performed by individual hospitals or physicians is not contained in report cards, which say nothing about the root causes of variations in quality. Rather, the key to quality improvement lies in an elaborate, careful process of investigating such questions as these: What sort of preoperative evaluations are performed? What is the intraoperative technique

of surgeons and anesthesiologists, and how does it compare with the best in the field? What is the process of postoperative management?

Quality improvement is, therefore, a painstaking and time-consuming business that depends for its success at least as much on our ability to modify the behavior of patients, purchasers, and providers of care as it does on the collection of good data about performance. The science of behavior modification in health care remains rudimentary. The provision of information to patients to guide their choices among plans and providers is a recent phenomenon. We need a much better understanding of how to disseminate such data in ways that are fair to providers, scientifically valid, and meaningful and useful to consumers. Then we need better methods of motivating providers, and especially health professionals, to use such data constructively. The quality of care cannot improve unless we harness the knowledge and creative energy of physicians and other health professionals for the purpose of redesigning the intricate, interlocking processes that constitute modern health care.<sup>4</sup>

#### PHYSICIANS AND THE FUTURE OF QUALITY MANAGEMENT

Clearly, therefore, the response of physicians to modern quality-management efforts is critical. Given the mixture of uncertainty and promise that characterizes the field at this point, how should physicians react? Perhaps the most appropriate attitude is a blend of hopefulness and skepticism — precisely the attitude with which many responsible health professionals have responded to the myriad new forms of medical technology that science has conjured up over the past century.

Hopefulness about the future of quality-management methods is justified by several considerations. The first is the important progress, chronicled by Brook et al.<sup>2</sup> and by Chassin,<sup>3</sup> toward developing valid, reliable, and useful techniques to measure and improve the quality of care. Although they have not yet been woven into systems of quality management that have been proved broadly effective in health care, such techniques have been efficacious in measuring and improving quality in particular settings.

A second and perhaps more important reason to be hopeful about the future of quality management is that it builds on medicine's long, successful tradition of improving its capabilities through the rigorous application of scientific methods to its daily work. Admittedly, the sciences that quality management relies on — statistics, epidemiology, psychology, sociology, and informatics — are younger and less familiar to physicians than the biomedical disciplines to which they are currently exposed in pre-clinical training. Only a century ago, however, biochemistry, physiology, and pharmacology (not to

speak of genetics) in their modern forms were equally immature and unfamiliar to practicing health professionals.<sup>20</sup>

Calling something scientific, however, does not make it useful. Science over the years has generated many innovations that, in widespread application, lack effectiveness or do more harm than good.<sup>21</sup> Physicians bear the awesome responsibility of deciding, with their patients, which new forms of technology are likely to improve the health of particular human beings, and they are justified, therefore, in treating such innovations with a hefty dose of skepticism.

Such skepticism is even more legitimate when those advancing the new technologies have — or appear to have — a financial interest in the outcome of their use. As Berwick notes,<sup>5</sup> the development and widespread application of guidelines, critical paths, computerized medical-information systems, customer-satisfaction surveys, and total-quality-management methods have coincided with the commercialization of the medical marketplace. The organizations promoting the use of such quality-improvement methods are not infrequently motivated, at least in part, by marketing goals. At other times, those promoting quality-management initiatives seem most interested in using them to reduce “medical loss ratios” (i.e., the costs of care)<sup>3</sup> and thereby increase profits.

As already noted in this series,<sup>1</sup> physicians may at times conclude that certain quality-assurance methods have been prematurely applied or misused. Circumstances may require that physicians oppose the adoption of certain quality-measurement or quality-improvement practices or make decisions about individual patients that are at variance with the policies of particular organizations. However, in adopting these positions, physicians should be aware and wary of several considerations.

First, they should be certain that the approaches or practices they are defending are superior to the alternatives they are rejecting. The fact that the data quality managers propose to collect may be imperfect does not mean that the alternative — collecting no data about the quality of care — is preferable. New quality-measurement systems should receive the same objective evaluation, including field testing, as any new form of technology, and they should be accepted by physicians if their benefits are likely to outweigh their risks.

Second, physicians must base their reaction to quality-management efforts on a careful assessment of their patients' interests and circumstances, as well as their own. In the end, neither physicians nor their patients will benefit from indiscriminate opposition to reform in the face of fundamental social and scientific upheaval. A far more useful and constructive strategy is to embrace change and to shape it for positive purposes.

In the effort to shape the quality-management revolution, physicians acting alone no longer have the credibility or the market power to influence greatly the decisions of organized purchasers or providers of health care services. Yet physicians do have a number of skills and attributes that no other participants in the health care marketplace have in quite the same combination: scientific training and understanding of medical diagnostics and therapeutics, an understanding of patients' individual circumstances, an ongoing personal relationship with patients, and perhaps most important, an ethical and professional commitment to placing patients' welfare first. The first three of these make physicians' advice authoritative. The last makes it trustworthy and creates a confluence of interests between physician and patient that could anchor an alliance that would be not only politically and economically irresistible, but also the source of profound ethical gratification to physicians.

At times, the views and interests of physicians and patients will differ and even conflict. We have described above the differing perspectives of physicians and patients as to whether and when to release data on the clinical performance of practitioners. To the extent that physicians share a fundamental, primary commitment to the welfare of patients, such differences can be bridged through mutual education and dialogue. However, these bridges may be far more difficult to build if the spread of capitation and risk-bearing arrangements for providers causes some patients to doubt that physicians continue to place the interests of their patients first. Whether or not such arrangements affect the quality of care, they have the potential to drive a wedge between physicians and patients that may fundamentally undermine physicians' ability to regain the authority they think they deserve in the evolving debate over quality.

Physicians need to find a way to make their perspective on quality measurement and improvement heard. They cannot accomplish this without new skills, attitudes, and partners. The success of physicians in acquiring these resources, and in avoiding entanglements that divide them from their patients, will powerfully affect the future both of the profession and of quality measurement and improvement in the U.S. health care system.

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